EMERGENCY NURSES ASSOCIATION of MICHIGAN

TESTIMONY BEFORE

MICHIGAN JUDICIARY COMMITTEE ON CRIMINAL JUSTICE

OCTOBER 9, 2013

EMERGENCY NURSES ASSOCIATION MICHIGAN STATE COUNCIL

SB 250 & SB 360 PROPONENT TESTIMONY

Presented by
Mark Kenneth Goldstein, RN, MSN, EMT-P I/C
2013 Michigan President, Executive Committee
2013 Government Affairs Liaison
Emergency Nurses Association Michigan State Council

Good morning Chairman Heise and distinguished committee members,

Thank you for the opportunity to testify today. My name is Mark Goldstein, a registered nurse and the State Council President speaking on behalf of the Michigan Emergency Nurses Association.

I have been an emergency care provider for 28 years. As previously noted, I am the Michigan ENA State Council President, a director of an emergency department and also the victim of work place violence. I have a bachelor of science in nursing degree and have also earned a master of science in nursing degree. I have clinical stretcher side experience as an emergency department staff nurse, educator for other nurses, and now a director of an emergency department. Our organization is a strong proponent of SB 250 and SB 360.

ENA is the only professional nursing association dedicated to defining the future of emergency nursing and emergency care through advocacy, innovation, and leadership. Founded in 1970, ENA serves the voice of more than 40,000 members worldwide (more than 1,300 in Michigan) and their patients through research, publications, professional development, injury prevention, and patient education[1-19]. As emergency nurses, Michigan ENA is deeply concerned by the increasing violence directed at our health care providers. The International Council of Nurses described this problem as a "world wide epidemic" in 2008.

As you may know, the landmark study published in the *Journal of Nursing Administration* indicated that emergency nurses are particularly vulnerable to workplace violence. Verbal abuse has been found to affect up to 100% of emergency nurses in some facilities[7]. Physical abuse is a significant risk as well[7]. A survey of over 3,400 ENA members conducted in October 2006 found that 86% had been victims of workplace violence in the preceding three years, with family members and visitors as likely to perpetrate abusive behavior as patients. Nearly 20% of nurses reported that they experience workplace violence frequently[7]. These abuses and assaults have a direct effect on staff morale, the amount of non-productive work and length of staff employment in our emergency departments. I personally have been the victim of these assaults, and I have also been witness to numerous other assaults on my coworkers including nurses, physicians, and unlicensed assistive personnel. These instances include personal death threats, watching a physician get tackled to the ground, witnessing another nurse being placed in a

headlock and slammed down to the ground resulting in rib fractures and having one of our techs suffer a fractured forearm secondary to having a patient grab her in a malicious manner. I have even stood beside a colleague, in her third trimester of pregnancy, when a patient called her a derogatory name and then threatened to kick her in the abdomen. And myself, I have been the victim of this violence over 28 years as an emergency care provider. A registered nurse. How do you explain to your children when you come home with a black eye or an injury as a result of taking care of a patient? A violent patient. Words cannot explain the pain we all experience, especially with your young children looking up to you.

One study's data reflected that over 70% of emergency department incidents go unreported to authorities[9]. Another study reported that 29% of nurses did not report their latest physical assault, and that verbal abuse which does not escalate to physical violence is seldom ever reported[10]. Reducing violence in the workplace is one of ENA's top three priorities at a national level[11]. With a philosophy of "Prevent, Respond, and Report," ENA is using tremendous resources to enhance data collection related to ED violence[12-14]. We have national workgroups working on understanding the epidemiology of the violence, and then generating useful solutions to mitigate it[13-14]. To this end our organization released a, "Workplace Violence Toolkit." This product, available online[14]. As ENA continues to do its part in addressing this epidemic, we ask our community leaders and legislators to help protect us as we serve the public.

Michigan ENA's top legislative priority for Michigan 96th Legislature is the passage of legislation that makes an assault or battery against a health care professional or health care worker a felony. Making it a felony to attack a health care professional should ensure an added level of safety. With this enhanced punishment, hopefully more emergency nurses will feel safer, which can help with nurse retention and recruitment. Something especially important during a time of nursing shortages.

To this end, Michigan ENA strongly supports SB 250 and SB 360. While particulars vary from state to state, felony legislation for assault and/or battery against an emergency nurse and health care providers exists in twenty-eight states: Alabama, Arizona, Arkansas, Connecticut, Colorado, Delaware, Florida, Illinois, Indiana, Iowa, Massachusetts, Minnesota, Missouri, Mississippi, Nevada, New Mexico, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Utah, Vermont, Virginia, Washington, West Virginia and Wisconsin[7,16-19].

The incidence of violence in our emergency departments is clearly documented[1-19]. It is true that nurses are the primary bedside caregiver and likewise the primary victims of assault. However patient's emergency department experience often includes interaction with other healthcare providers including physicians, midlevel providers, phlebotomists, and nursing assistants. Our work together as a team is critical to the success or failure of the care we deliver[19]. We are particularly pleased with the inclusive language of "Health care professional, health care worker, or hospital security officer" as written in SB 250 and SB 360. As we continue conversation on this issue, we also need to talk about equality of protection - under the law - for those working in public service industries.

The State of Michigan has already afforded similar protection to the following professionals:

- Peace officers and investigators
- Firefighters
- Emergency Medical Service Providers
- School teachers, School Administrators, and School Bus Operators

Michigan ENA is extremely excited to see SB 250 and SB 360 was amended to include other bedside professionals. The legislation you have before you today, as passed by the senate, has our total support. What we are asking for is equality of protection already shared by other public service professionals. Nothing more, and nothing less.

Thank you for the opportunity to testify today and I would be happy to answer any questions you might have.

References
(References with an asterisk are attached)

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List of Attachments

A. Violence in the Emergency Department: Leave behind for legislators
B. ENA Position Statement: Violence in the emergency care setting
C. HCA, Inc. (2009).50 state survey of misdemeanor and felony laws.
D. Leblond, M. (2011). The roller coaster ride of assault legislation — a tale of the ups and downs in Texas. ENA Connection. 35:9, 25. Retrieved online November 15, 2011 from http://www.ena.org/publications/connection/Online/2011/Documents/10-2011.pdf
E. Gacki-Smith, J., Juarez, A.M., Boyett, L., Homeyer, C., Robinson, L., & MacLean, S.L. (2009). Violence against nurses working in US emergency departments. *Journal of Nursing Administration*. 39:7/8, 340-349.
F. Roche, M., Diers, D., Duffield, C., & Catling-Paull, C. (2010). Violence toward nurses, the work environment, and patient outcomes. *Journal of Nursing Scholarship*. 42:1, 13–22.

Attachment A

EMERGENCY NURSES ASSOCIATION of MICHIGAN

Mark Goldstein, RN, MSN, EMT-P I/C
SB 250 & SB 360 Testimony: 10/9/2013
96th Michigan Legislature

VIOLENCE IN THE EMERGENCY DEPARTMENT

ENA POSITION

The Emergency Nurses Association (ENA) is actively working to reduce the risk of workplace violence to which emergency department nurses are exposed in the course of their normal work day. ENA, therefore, supports legislation that increases penalties against individuals who assault nurses and other health care workers.

ISSUE

Results from the U.S. Department of Justice's ***2001 National Crime Victimization Survey – 1993 to 1999*** state that the average annual rate for nonfatal violent crime for all occupations was 12.6 per 1,000 workers, compared to 21.9 for nurses. Data released by the U.S. Bureau of Labor Statistics in 2004 show that among health care practitioners, 46% of all nonfatal assaults and violent acts involving days away from work were committed against registered nurses.

RATIONALE

The National Institute for Occupational Safety and Health at the Centers for Disease Control and Prevention (CDC) has reported that factors related to an increased risk for workplace violence include routine face-to-face contact with large numbers of people. A majority of the non-fatal assaults are reported from the service and retail sectors. In the service sector, 38% of non-fatal assaults occurred in health care settings, while 13% occurred in social service settings.

Emergency nurses are particularly vulnerable to workplace violence. A survey of 1,000 ENA members conducted in October 2006 found that 86% had been the victim of workplace violence in the preceding three years, with family members and visitors as likely to perpetrate abusive behavior as patients. Nearly 20% reported that they experience workplace violence frequently.

The stress of workplace violence can contribute to job dissatisfaction. Among nursing staffs, it can cause low worker morale, high rates of sick time, and shorten lengths of employment. In an era of nursing shortages, this added stress may make certain workplaces less desirable for nurses to select for employment.

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Attachment B

EMERGENCY NURSES ASSOCIATION of MICHIGAN

Mark Goldstein, RN, MSN, EMT-P I/C
SB 250 & SB 360 Testimony: 10/9/2013
96th Michigan Legislature

VIOLENCE IN THE EMERGENCY CARE SETTING

Workplace violence is a serious occupational risk for the emergency nursing workforce and has been recognized as a violent crime that requires targeted responses from employers, law enforcement, and the community. Workplace violence can be defined as an act of aggression, physical assault, emotional or verbal abuse, coercive or threatening behavior that occurs in a work setting and causes physical or emotional harm. The health care industry leads all other sectors in the incidence of nonfatal workplace assaults, and the emergency department is a particularly vulnerable setting. A significant amount of workplace violence is preventable. Workplace violence prevention programs should include leadership's commitment and employee involvement, worksite analysis of existing or potential hazards for workplace violence, measures for violence prevention and control, safety and training for staff, and record keeping and program evaluation to determine program evaluation. Health care organizations must take preventive measures to circumvent workplace violence and ensure the safety of all health care workers, their patients, and visitors.

It is the position of the Emergency Nurses Association that:

1. The risk of workplace violence is a significant occupational hazard facing emergency nurses. Health care organizations have a responsibility to provide a safe and secure environment for their employees and the public.

2. Lack of a violence prevention program is associated with an increased assault risk in hospitals. Health care organizations should implement an interdisciplinary approach to establish a workplace violence prevention program. Emergency nurses should play an integral role in all aspects of violence prevention planning and monitoring. Prevention strategies for reducing exposure to violence risk should include environmental designs to provide a safe workplace, administrative controls to ensure safe staffing patterns and adequate security measures, and training workers to recognize and manage potential assaults.

3. Emergency nurses have the responsibility to report incidents of violence and abuse to their employer, without fear of reprisal, as well as the right to report incidents to local law enforcement authorities and pursue legal action. Procedures for reporting violent incidents should be clear and consistent.

4. Health care organizations support a "zero tolerance" policy for workplace violence. Health care organizations should provide safety training programs specific to the emergency setting for health care workers to recognize, mitigate, avoid, and defuse potential violent situations.

5. Health care organizations should provide professional debriefing and medical care for employees exposed to workplace violence with the option of obtaining further counseling.

6. Emergency departments should have trained and equipped security personnel and structural/environmental controls to provide adequate and appropriate barriers against acts of violence.

7. Legislation that mandates and regulates safety standards and controls for workplace violence prevention should be strengthened and supported.

8. Stronger legislation to protect emergency nurses that have been victims of workplace violence helps to reinforce the standard that violence is not part of the job. Felony legislation and penalties for workplace violence, including assault or battery against emergency nurses and their health care colleagues, should be strengthened and supported in every state.

9. Emergency nurses should be involved in research that increases understanding of workplace violence as it relates to the emergency department and identifies effective workplace safety measures and strategies needed to prevent and mitigate violent incidents.

Resources

Emergency Nurses Association (2011). ENA Workplace Violence Management Toolkit. Retrieve from http://www.ena.org/ENR/Pages/WorkplaceViolence.aspx.

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Developed: 1991.

Approved by the ENA Board of Directors: July 1991.
Revised and Approved by the ENA Board of Directors: September 1993.
Revised and Approved by the ENA Board of Directors: April 1995.
Revised and Approved by the ENA Board of Directors: September 1997.
Revised and Approved by the ENA Board of Directors: December 1999.
Revised and Approved by the ENA Board of Directors: July 2001.
Revised and Approved by the ENA Board of Directors: April 2006.
Revised and Approved by the ENA Board of Directors: September 2008.
Revised and Approved by the ENA Board of Directors: December 2010.

Attachment C

EMERGENCY NURSES ASSOCIATION of MICHIGAN

Mark Goldstein, RN, MSN, EMT-P I/C
SB 250 & SB 360 Testimony: 10/9/2013
96th Michigan Legislature

50 State Survey Criminal Laws
Protecting Health Professionals
Updated May 2013

State	Statute	Relevant Text	Status
Alabama **Back To Top**	AL Code § 13A-6-21	Assault in the second degree is a Class C felony. A person commits the crime of assault in the Second Degree if the person: With intent to cause physical injury to a health care worker, including a nurse, physician, technician, or any other person employed by or practicing at a hospital as defined in § 22-21-20; a county or district health department; a longterm care facility; or a physician's office, clinic, or outpatient treatment facility during the course of or as a result of the performance of the duties of the health care worker or other person employed by or practicing at the hospital; the county or district health department; any health care facility owned or operated by the State of Alabama; the long-term care facility; or the physician's office, clinic, or outpatient treatment facility; he or she causes physical injury to any person. This subdivision shall not apply to assaults by patients who are impaired by medication or to assaults on home health care workers while they are in private residences.	Effective 2006
Alaska **Back To Top**	AK Statute Sec. § 12.55.135	A defendant convicted of assault in the fourth degree or harassment in the first degree who knowingly directed the conduct constituting an offense at: Emergency medical technician or medical professional "medical professional" means a nurse, nurse aid, or nurse practitioner	Effective

Arizona **Back To Top**	AZ Revised Statute §13-1204	A person commits aggravated assault if the person commits assault, and the person committing the assault knows or has reason to know that the victim is a licensed or certified health care practitioner. This does not apply if the person who commits the assault is seriously mentally ill, as defined in section 36-550, or is afflicted with Alzheimer's disease or related dementia	Effective
Arkansas **Back To Top**	AR Code §5-13-202	A person commits battery in the second degree if the person knowingly, without legal justification, causes physical injury to a person he or she knows to be, while performing medical treatment or emergency medical services or while in the course of other employment relating to his or her medical training, (i) a physician; (ii) a person certified as an emergency medical technician; (iii) a licensed or certified health care professional; or any other health care provider. Battery in the second degree is a class D felony.	Effective
	House Bill 1026 Introduced by: Rep. B. Wilkins	Aggravated assault is a class C Felony; Assault in the first degree is a class D felony; Assault in the second degree is a class A misdemeanor; Assault in the third degree is a class B misdemeanor if the victim is: While performing medical treatment or emergency medical services or while in the course of other employment relating to his or her medical training: A person certified as an emergency medical services personnel; a licensed or certified health care professional; or any health care provider	Died in House Commmittee at Adjournment

California **Back To Top**	CA Penal Code § 241, § 243	When an assault is committed against the person of an emergency medical technician engaged in the performance of his or her duties, or a nurse engaged in rendering emergency medical care outside a hospital, clinic, or other health care facility, and the person committing the offense knows or reasonably should know that the victim is an emergency medical technician engaged in the performance of his or her duties, or a nurse engaged in rendering emergency medical care, the assault is one year, or by both that fine and imprisonment. When a battery is committed against an emergency medical technician engaged in the performance of his or her duties, whether on or off duty, or a nurse engaged in rendering emergency medical care outside a hospital, clinic, or other health care facility, and the person committing the offense knows or reasonably should know that the victim is an emergency medical technician, engaged in the performance of his or her duties, or a nurse engaged in rendering emergency medical care, and an injury is inflicted on that victim, the battery is punishable by a fine of not more than $2,000, by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment. When a battery is committed against the person of an emergency medical technician engaged in the performance of his or her duties, whether on or off duty, or a nurse engaged in rendering emergency medical care outside a hospital, clinic, or other health care facility, and the person committing the offense knows or reasonably should know that the victim is an emergency medical technician, engaged in the performance of his or her duties, or a nurse engaged in rendering emergency medical care, the battery is punishable by a fine not exceeding two thousand dollars ($2,000), or by imprisonment in a county jail not exceeding one year, or by both imprisonment in the state prison for 16 months, or two or three years.	Effective

Colorado **Back To Top**	CO Revised Statute § 18-1.3-501	If a defendant is convicted of assault in the third degree under section 18-3-204 and the victim is a peace officer, emergency medical service provider, emergency medical care provider, or firefighter engaged in the performance of his or her duties, notwithstanding subsection (1) of this section, the court shall sentence the defendant to a term of imprisonment greater than the maximum sentence but no more than twice the maximum sentence authorized for the same crime when the victim is not a peace officer, emergency medical service provider, emergency medical care provider, or firefighter engaged in the performance of his or her duties.	Effective
	CO Revised Statute § 18-3-204	A person commits the crime of assault in the third degree if: (a) The person knowingly or recklessly causes bodily injury to another person or with criminal negligence the person causes bodily injury to another person by means of a deadly weapon; or (b) The person, with intent to infect, injure, harm, harass, annoy, threaten, or alarm another person whom the actor knows or reasonably should know to be a peace officer, a firefighter, an emergency medical care provider, or an emergency medical service provider, causes the other person to come into contact with blood, seminal fluid, urine, feces, saliva, mucus, vomit, or toxic, caustic, or hazardous material by any means, including throwing, tossing, or expelling the fluid or material.	Effective
Connecticut **Back To Top**	CT Revised Statutes § Sec. 53a-167c	Assault of public safety, emergency medical, public transit or health care personnel is a class C felony. If any person who is confined in an institution or facility of the Department of Correction is sentenced to a term of imprisonment for assault of an employee of the Department of Correction under this section, such term shall run consecutively to the term for which the person was serving at the time of the assault. In any prosecution under this section involving assault of a health care employee, as defined in section 19a-490q, it shall be a defense that the defendant is a person with a disability as described in subdivision (13), (15) or (20) of section 46a-51 and the defendant's conduct was a clear and direct manifestation of the disability.	Effective

Delaware **Back To Top**	DE Code 11, § 612	A person is guilty of assault in the second degree (class D felony) when: The person intentionally causes physical injury to am emergency medical technician. It shall be a class C felony if the person recklessly or intentionally causes physical injury by means of an electronic control device.	Effective 2010
	DE Code 11, § 613	A person is guilty of assault in the first degree (class B felony) when intentionally causes serious physical injury to a medical technician.	Effective 210
District of Columbia	N/A	N/A	N/A
Florida **Back To Top**	FL Statute §784.07	Assault or battery of emergency medical care providers results in reclassification of the crime: (a) In the case of assault, from a misdemeanor of the second degree to a misdemeanor of the first degree. (b) In the case of battery, from a misdemeanor of the first degree to a felony of the third degree. (c) In the case of aggravated assault, from a felony of the third degree to a felony of the second degree. (d) In the case of aggravated battery, from a felony of the second degree to a felony of the first degree. "Emergency medical care provider" includes emergency medical technician and registered nurse, or any person authorized by an emergency medical service licensed under Chapter 401 who is engaged in the performance of his or her duties.	Effective
Georgia	N/A	N/A	N/A

Hawaii **Back To Top**	HI Revised Statutes § 707-711	A person commits the offense of assault in the second degree if the person intentionally or knowingly causes bodily injury to any emergency medical services personnel who is engaged in the performance of duty. Assault in the second degree is a class C felony.	Effective
	HI Revised Statutes § 707-712.7	1) A person commits the offense of assault against an emergency worker if the person, during the time of a civil defense emergency proclaimed by the governor pursuant to Chapter 128, within the area covered by the civil defense emergency or during the period of disaster relief under Chapter 127: (a) Intentionally, knowingly, or recklessly causes serious or substantial bodily injury to an emergency worker; or (b) Intentionally, knowingly, or recklessly causes bodily injury to an emergency worker with a dangerous instrument. (2) Assault against an emergency worker is a class B felony.	Effective
Idaho **Back To Top**	ID CODE § 18-915	The punishment for any person who commits a crime upon an emergency medical technician certified by the department of health and welfare, emergency medical technician-ambulance certified by the department of health and welfare, advanced emergency medical technician and EMT-paramedic certified by the state board of medicine shall be as follows: (a) For committing battery with intent to commit a serious felony the punishment shall be imprisonment in the state prison not to exceed twenty-five (25) years. (b) For committing any other crime in this chapter the punishment shall be doubled that provided in the respective section.	Effective

Illinois **Back To Top**	720 IL Statutes § 5/12-2	A person commits an aggravated assault, when, in committing an assault, he: Knows the individual assaulted to be an emergency medical technician -- intermediate, emergency medical technician -- other medical assistance or first aid personnel engaged in the execution of any of his official duties, or to prevent the emergency medical technician -- ambulance, emergency medical technician -- intermediate, emergency medical technician from performing his official duties, or in retaliation for the emergency medical technician -- ambulance, emergency medical technician -- intermediate, emergency medical technician performing his official duties. Aggravated assault is a Class A misdemeanor if a firearm was not used in the commission of the assault. If a firearm was used, aggravated assault is a Class 4 felony.	Effective
	720 IL Statutes § 5/12-4	In committing a battery, a person commits aggravated battery if he: Knows the individual harmed to be an emergency medical technician -- ambulance, emergency medical technician -- intermediate, emergency medical technician -- paramedic, ambulance driver, other medical assistance, first aid personnel, or hospital personnel engaged in the performance of any of his or her official duties, or to prevent the emergency medical technician -- ambulance, emergency medical technician -- intermediate, emergency medical technician -- paramedic, ambulance driver, other medical assistance, first aid personnel, or hospital personnel from performing official duties, or in retaliation for performing official duties. Aggravated battery is a Class 3 felony.	Effective

Indiana	IN Code § 35-42-2-1	A person who knowingly or intentionally touches another person in a rude, insolent, or angry manner commits battery, a Class B misdemeanor. The offense is a Class D felony if it results in bodily injury to a person who is a health care provider while the health care provider is engaged in the execution of the health care provider's official duty.	Effective
Iowa **Back To Top**	IA Code § 708.3A	A person who commits an assault against a health care provider with the intent to inflict a serious injury or uses a dangerous weapon on the health care provider is guilty of a class D felony. A person who commits an assault against a health care provider who knows that the person against whom the assault is committed is a health care provider is guilty of a class D felony. Any other assault committed against a health care provider by a person who knows that the person against whom the assault is committed is a health care provider is a serious misdemeanor.	Effective

Kansas **Back To Top**	KS Statute § 21-3444	**Unlawful interference with an emergency medical services attendant.** (a) Unlawful interference with an emergency medical services attendant is knowingly and intentionally interfering with, molesting or assaulting, any attendant while engaged in the performance of such attendant's duties, or knowingly and intentionally obstructing, interfering with or impeding the efforts of any attendant to reach the location of an emergency. (b) "Attendant" means a first responder, emergency medical technician, emergency medical technician-intermediate, emergency medical technician-defibrillator or a mobile intensive care technician certified pursuant to this act. (c) Unlawful interference with an emergency medical services attendant is a class B person misdemeanor.	Effective
	KS Statute § 21-3448	Battery against a mental health employee. (a) Battery against a mental health employee is a battery, as defined in K.S.A. 21-3412, and amendments thereto, committed against a mental health employee by a person in the custody of the secretary of social and rehabilitation services, while such employee is engaged in the performance of such employee's duty. (b) Battery against a mental health employee is a severity level 7, person felony. (c) As used in this section "mental health employee" means an employee of the department of social and rehabilitation services working at Learned state hospital, Osawatomie state hospital and Rainbow mental health facility, Kansas neurological institute and Parsons state hospital and training center and the treatment staff as defined in K.S.A. 59-29a02, and amendments thereto.	Effective

Kentucky	KY. Revised Statute § 508.025	A person is guilty of assault in the third degree when the actor recklessly, with a deadly weapon or dangerous instrument, or intentionally causes or attempts to cause physical injury to paid or volunteer emergency medical services personnel, if the event occurs while personnel are performing job-related duties. Assault in the third degree is a Class D felony	Effective
Louisiana **Back To Top**	LA Revised Statute § 14:332	**Interference with medical treatment** A) Interference with medical treatment is the intentional and willful interference with a nurse, nurse's aide, emergency medical technician, or other medical or hospital personnel in the performance of their duties relating to the care and treatment of patients in any hospital, clinic, other medical facility, or at the scene of a medical emergency. B.) Whoever violates the provisions of this Section shall be fined not less than one hundred dollars or more than two hundred and fifty dollars upon conviction of a first offense, and not less than two hundred fifty dollars or more than five hundred dollars or ten days in jail or both upon conviction of any subsequent offense.	Effective
Maine	N/A	N/A	N/A
Maryland	N/A	N/A	N/A

Massachusetts **Back To Top**	MA LAWS CH. 265 § 13I	Whoever commits an assault or assault and battery on an emergency medical technician, an ambulance operator, or an ambulance attendant, while said technician, operator or attendant is treating or transporting, in the line of duty, a person, shall be punished by imprisonment in the house of correction for not less than ninety days nor more than two and one-half years, or by a fine of not less than five hundred nor more than five thousand dollars, or both.	Effective
	HB 1508	**An Act to authorize the arrest for assault and battery on a public employee** Any officer authorized to make arrests may arrest without a warrant any person who he has probable cause to believe has committed the assault or assault and battery on an emergency medical technician, an ambulance operator, or an ambulance attendant, while said technician, operator or attendant is treating or transporting, in the line of duty and may keep said person in custody for not more than twenty-four hours, or until the next sitting of the court, during which period the officer shall seek the issuance of a complaint and request a bail determination.	Referred to Committee on Judiciary 1/22/13

Michigan **Back To Top**	MI Compiled Laws § 750.81d	"Person" means any of the following: Any emergency medical service personnel. (1) An individual who assaults, batters, wounds, resists, obstructs, opposes, or endangers a person who the individual knows or has reason to know is performing his or her duties is guilty of a felony punishable by imprisonment for not more than 2 years or a fine of not more than $2,000.00, or both. (2) An individual who assaults, batters, wounds, resists, obstructs, opposes, or endangers a person who the individual knows or has reason to know is performing his or her duties causing a bodily injury requiring medical attention or medical care to that person is guilty of a felony punishable by imprisonment for not more than 4 years or a fine of not more than $5,000.00, or both. (3) An individual who assaults, batters, wounds, resists, obstructs, opposes, or endangers a person who the individual knows or has reason to know is performing his or her duties causing a serious impairment of a body function of that person is guilty of a felony punishable by imprisonment for not more than 15 years or a fine of not more than $10,000.00, or both. (4) An individual who assaults, batters, wounds, resists, obstructs, opposes, or endangers a person who the individual knows or has reason to know is performing his or her duties causing the death of that person is guilty of a felony punishable by imprisonment for not more than 20 years or a fine of not more than $20,000.00, or both.	Effective
Minnesota	MN Statute § 609.2231	Whoever assaults any of the following persons and inflicts demonstrable bodily harm is guilty of a felony and may be sentenced to imprisonment for not more than two years or to payment of a fine of not more than $4,000, or both: physician, nurse, or other person providing health care services in a hospital emergency department.	Effective

Mississippi	MS Code § 97-3-7	A person convicted of simple assault on emergency medical personnel or public health personnel acting within the scope of his duty, office or employment shall be punished by a fine of not more than One Thousand Dollars ($1,000.00) or by imprisonment for not more than five (5) years, or both. A person convicted of aggravated assault on emergency medical personnel or public health personnel acting within the scope of his duty, office or employment shall be punished by a fine of not more than Five Thousand Dollars ($5,000.00) or by imprisonment for not more than thirty (30) years, or both.	Effective
Missouri **Back To Top**	MO Revised Statute § 565.081	As used in this section, "emergency personnel" means any paid or volunteer firefighter, emergency room or trauma center personnel, or emergency medical technician. A person commits the crime of assault of emergency personnel in the first degree if such person attempts to kill or knowingly causes or attempts to cause serious physical injury to emergency personnel. Assault of emergency personnel in the first degree is a class A felony	Effective

Missouri **Back To Top**	MO Revised Statute § 565.082	A person commits the crime of assault of emergency personnel in the second degree if such person: (1) Knowingly causes or attempts to cause physical injury to emergency personnel by means of a deadly weapon or dangerous instrument; (2) Knowingly causes or attempts to cause physical injury to emergency personnel by means other than a deadly weapon or dangerous instrument; (3) Recklessly causes serious physical injury to emergency personnel; or (4) While in an intoxicated condition or under the influence of controlled substances or drugs, operates a motor vehicle or vessel in this state and when so operating, acts with criminal negligence to cause physical injury emergency personnel; (5) Acts with criminal negligence to cause physical injury to emergency personnel by means of a deadly weapon or dangerous instrument; (6) Purposely or recklessly places emergency personnel in apprehension of immediate serious physical injury; or (7) Acts with criminal negligence to create a substantial risk of death or serious physical injury to emergency personnel. Assault of emergency personnel in the second degree is a class B felony unless committed pursuant to subdivision (2), (5), (6), or (7) of subsection 1 of this section in which case it is a class C felony.	Effective

Missouri **Back To Top**	MO Revised Statute § 565.083	A person commits the crime of assault of emergency personnel in the third degree if: (1) Such person recklessly causes physical injury to emergency personnel; (2) Such person purposely places emergency personnel in apprehension of immediate physical injury; (3) Such person knowingly causes or attempts to cause physical contact with emergency personnel without the consent of the emergency personnel. Assault of emergency personnel in the third degree is a class A misdemeanor.	Effective

		A person commits the offense of assault with a bodily fluid if the person purposely causes one of the person's bodily fluids to make physical contact with a health care provider, including a health care provider performing emergency services, while the health care provider is acting in the course and scope of the health care provider's profession and occupation: (i) during or after an arrest for a criminal offense; (ii) while the person is incarcerated in or being transported to or from a state prison, a county, city, or regional jail or detention facility, or a health care facility; or (iii) if the person is a minor, while the youth is detained in or being transported to or from a county, city, or regional jail or detention facility or a youth detention facility, secure detention facility, regional detention facility, short-term detention center, state youth correctional facility, health care facility, or shelter care facility.	
Montana **Back To Top**	MT CODE § 45-5-214	A person commits the offense of assault with a bodily fluid if the person purposely causes one of the person's bodily fluids to make physical contact with an emergency responder. "Bodily fluid" means any bodily secretion, including but not limited to feces, urine, blood, and saliva. "Emergency responder" means a licensed medical services provider, law enforcement officer, firefighter, volunteer firefighter or officer of a nonprofit volunteer fire company, emergency medical technician, emergency nurse, ambulance operator, provider of civil defense services, or any other person who in good faith renders emergency care or assistance at a crime scene or the scene of an emergency or accident. A person convicted of the offense of assault with a bodily fluid shall be fined an amount not to exceed $ 1,000 or incarcerated in a county jail or a state prison for a term not to exceed 1 year, or both.	Effective

Montana	MT House Bill NO. 269 by K. Swanson	**Assault on a health care provider or emergency responder -- penalty -- definitions** (1) A person commits the offense of assault on a health care provider or emergency responder if, while a health care provider or emergency responder is performing professional duties, the person: (a) purposely or knowingly causes bodily injury to the health care provider or emergency responder (b) negligently causes bodily injury to the health care provider or emergency responder with a weapon; (c) purposely or knowingly causes the health care provider or emergency responder reasonable apprehension of bodily injury. (2) A person convicted of assault on a health care provider or emergency responder shall be fined an amount not to exceed $50,000 or be imprisoned for a term not to exceed 10 years, or both.	Died in Standing Committee
Nebraska **Back To Top**	NE Revised Statute § 28-930	A person commits the offense of assault on a health care professional in the second degree, if he or she, intentionally or knowingly or recklessly causes bodily injury with a dangerous instrument to a health care professional while on duty at a hospital or health clinic. Assault on a health care professional in the second degree shall be a class II felony.	Effective
	NE Revised Statute § 28-931	A person commits the offense of assault on a health care professional in the third degree, if he or she, intentionally, knowingly, or recklessly causes bodily injury to a health care professional while on duty at a hospital or health clinic. Assault on a health care professional in the third degree shall be a class IIIA felony.	Effective

Nevada **Back To Top**	NV Revised Statute § 200.471	A person convicted of an assault shall be punished: If the assault is committed upon a provider of health care who is performing his duty, and the person charged knew or should have known that the victim was a provider of health care, for a gross misdemeanor, unless the assault is made with the use of a deadly weapon, or the present ability to use a deadly weapon, then for a category B felony by imprisonment in the state prison for a minimum term of not less than 1 year and a maximum term of not more than 6 years, or by a fine of not more than $5,000, or by both fine and imprisonment. If the assault is committed upon a provider of health care who is performing his duty and the probationer, prisoner or parolee charged knew or should have known that the victim was a provider of health care, for a category D felony as provided in NRS 193.130, unless the assault is made with the use of a deadly weapon, or the present ability to use a deadly weapon, then for a category B felony by imprisonment in the state prison for a minimum term of not less than 1 year and a maximum term of not more than 6 years, or by a fine of not more than $5,000, or by both fine and imprisonment.	Effective
New Hampshire **Back To Top**	NH House Bill 217	**Extended Imprisonment; Assault on a Health Care Provider.** Amend RSA 651:6, I(g) to read as follows: (g) Has knowingly committed or attempted to commit any of the crimes defined in RSA 631 where he or she knows the victim was, at the time of the commission of the crime, a law enforcement officer, a paid firefighter, volunteer firefighter, on-call firefighter, [or] licensed emergency medical care provider as defined in RSA 153-A:2, V, or any person who is a direct provider of health care including a physician, nurse, physician's assistant, or ancillary personnel employed by or under the supervision of a physician, or any other person whose primary function is to provide health care to another individual acting in the line of duty	Referred to Criminal Justice and Public Safety Committee; Hearing held 1/29/13

New Mexico **Back To Top**	NM Statute § 30-3-9.2	(1) "health facility" means a public or private hospital, outpatient facility, diagnostic and treatment center, rehabilitation center or infirmary. "Health facility" also includes those facilities that, by federal regulation, must be licensed by the state to obtain or maintain full or partial, permanent or temporary federal funding, but "health facility" does not include a skilled nursing facility, a nursing facility or other long- term residential care facility; (2) "health care worker" means an employee of a health facility or a licensed emergency medical technician; and (3) "in the lawful discharge of the health care worker's duties" means engaged in the performance of the duties of a health care worker. B. Assault upon a health care worker consists of: (1) an attempt to commit a battery upon the person of a health care worker who is in the lawful discharge of the health care worker's duties; or Whoever commits assault upon a health care worker is guilty of a misdemeanor	Effective

New Mexico **Back To Top**	NM Statute § 30-3-9.2 (Cont.)	(2) any unlawful act, threat or menacing conduct that causes a health care worker who is in the lawful discharge of the health care worker's duties to reasonably believe that the health care worker is in danger of receiving an immediate battery. Whoever commits assault upon a health care worker is guilty of a misdemeanor. C. Aggravated assault upon a health care worker consists of: (1) unlawfully assaulting or striking at a health care worker with a weapon while the health care worker is in the lawful discharge of the health care worker's duties; or (2) willfully and intentionally assaulting a health care worker who is in the lawful discharge of the health care worker's duties with intent to commit any felony. Whoever commits aggravated assault upon a health care worker is guilty of a third degree felony.	Effective
		D. Assault with intent to commit a violent felony upon a health care worker consists of assaulting a health care worker who is in the lawful discharge of the health care worker's duties with intent to kill the health care worker. Whoever commits assault with intent to commit a violent felony upon a health care worker is guilty of a second degree felony. E. Battery upon a health care worker is the unlawful, intentional touching or application of force to the person of a health care worker who is in the lawful discharge of the health care worker's duties, when done in a rude, insolent or angry manner. Whoever commits battery upon a health care worker is guilty of a fourth degree felony.	

New Mexico **Back To Top**	NM Statute § 30-3-9.2 (Cont.)	Whoever commits aggravated battery upon a health care worker, inflicting an injury to the health care worker that is not likely to cause death or great bodily harm but does cause painful temporary disfigurement or temporary loss or impairment of the functions of any member or organ of the body, is guilty of a fourth degree felony. Whoever commits aggravated battery upon a health care worker, inflicting great bodily harm or does so with a deadly weapon or in any manner whereby great bodily harm or death can be inflicted, is guilty of a third degree felony.F. Aggravated battery upon a health care worker consists of the unlawful touching or application of force to the person of a health care worker with intent to injure that health care worker while the health care worker is in the lawful discharge of the health care worker's duties. G. A person who assists or is assisted by one or more other persons to commit a battery upon a health care worker who is in the lawful discharge of the health care worker's duties is guilty of a fourth degree felony.	Effective
New Jersey **Back To Top**	NJ Revised Statutes § 2C:12-1	A person is guilty of aggravated assault if he commits a simple assault upon: Any person engaged in emergency first-aid or medical services acting in the performance of his duties while in uniform or otherwise clearly identifiable as being engaged in the performance of emergency first-aid or medical services. Aggravated assault under this circumstance is a crime of the third degree if the victim suffers bodily injury, otherwise it is a crime of the fourth degree.	Effective

New York	NY Penal Code § 120.05, 120.08	A person is guilty of assault in the second degree when: With intent to prevent an emergency medical service paramedic or emergency medical service technician, or medical or related personnel in a hospital emergency department, from performing a lawful duty, by means including releasing or failing to control an animal under circumstances evincing the actor's intent that the animal obstruct the lawful activity of such paramedic, technician, he or she causes physical injury to such paramedic, technician or medical or related personnel in a hospital emergency department. Assault in the second degree is a class D felony. A person is guilty of assault on an emergency medical services professional when, with intent to prevent an emergency medical service paramedic or emergency medical service technician, from performing a lawful duty, he causes serious physical injury to such paramedic or technician. Assault on an emergency medical services professional is a class C felony.	Effective
New York **Back To Top**	NY AB 6079 by A. Lentol	A person is guilty of reckless assault upon an emergency medical service paramedic or technician when he or she recklessly causes physical injury to an emergency medical service paramedic or technician while performing their duty, irrespective of whether such assault results in impairment of physical condition or substantial pain. Reckless Assault upon an emergency medical paramedic or technician is a class E felony.	Referred to Codes

North Carolina **Back To Top**	NC General Statute § 14-34.6	(a) A person is guilty of a Class A1 misdemeanor if the person commits an assault or an affray on any of the following persons who are discharging or attempting to discharge their official duties: (1) An emergency medical technician. (2) A medical responder. (3) An emergency department nurse. (4) An emergency department physician. Unless a person's conduct is covered under some other provision of law providing greater punishment, a person is guilty of a Class I felony if the person violates subsection (a) of this section and (i) inflicts serious bodily injury or (ii) uses a deadly weapon other than a firearm. Unless a person's conduct is covered under some other provision of law providing greater punishment, a person is guilty of a Class F felony if the person violates subsection (a) of this section and uses a firearm.	Effective

North Dakota **Back To Top**	ND Century Code § 12.1-17-01	1. A person is guilty of simple assault if that person: a. Willfully causes bodily injury to another human being; or b. Negligently causes bodily injury to another human being by means of a firearm, destructive device, or other weapon, the use of which against a human being is likely to cause death or serious bodily injury. The offense is a class C felony when the victim is a member of an emergency medical services personnel unit or emergency department worker in the performance of the member's duties.	Effective
Ohio **Back To Top**	OH Revised Code § 2903.13	If the victim of the offense is a health care professional of a hospital, a health care worker of a hospital, or a security officer of a hospital whom the offender knows or has reasonable cause to know is a health care professional of a hospital, a health care worker of a hospital, or a security officer of a hospital, if the victim is engaged in the performance of the victim's duties, and if the hospital offers de-escalation or crisis intervention training for such professionals, workers, or officers, assault is one of the following: (a) Except as otherwise provided in division (C)(7)(b) of this section, assault committed in the specified circumstances is a misdemeanor of the first degree. Notwithstanding the fine specified in division (A)(2)(b) of section 2929.28 of the Revised Code for a misdemeanor of the first degree, in sentencing the offender under this division and if the court decides to impose a fine, the court may impose upon the offender a fine of not more than five thousand dollars. (b) If the offender previously has been convicted of or pleaded guilty to one or more assault or homicide offenses committed against hospital personnel, assault committed in the specified circumstances is a felony of the fifth degree.	Effective

Oklahoma **Back To Top**	OK Statute Title 21 § 650.3	Every person who willfully delays, obstructs or in any way interferes with an emergency medical technician or other emergency medical care provider in the performance of or attempt to perform emergency medical care and treatment or in going to or returning from the scene of a medical emergency, upon conviction, is guilty of a misdemeanor punishable by imprisonment in the county jail not exceeding six (6) months, or by a fine not to exceed Five Hundred Dollars ($500.00), or by both such fine and imprisonment.	Effective
	OK Statute Title 21 § 650.4	Assault and battery upon emergency medical care providers. A. Every person who, without justifiable or excusable cause and with intent to do bodily harm, commits any assault, battery or assault and battery upon the person of an emergency medical care provider who is performing medical care duties, upon conviction, is guilty of a felony punishable by imprisonment in the custody of the Department of Corrections for a term not exceeding two (2) years, or by a fine not exceeding One Thousand Dollars ($1,000.00), or by both such fine and imprisonment. B. As used in this section, "emergency medical care provider" means doctors, residents, interns, nurses, nurses' aides, ambulance attendants and operators, paramedics, emergency medical technicians, and members of a hospital security force.	Effective
	OK Statute Title 21 § 650.5	Aggravated assault and battery or assault with firearm or other dangerous weapon upon emergency medical technician or other emergency medical care provider - Penalty. Every person who, without justifiable or excusable cause and with intent to do bodily harm, commits any aggravated assault and battery or any assault with a firearm or other deadly weapon upon the person of an emergency medical technician or other emergency medical care provider, upon conviction, is guilty of a felony punishable by imprisonment in a state correctional institution for not more than one (1) year, or by a fine not to exceed One Thousand Dollars ($1,000.00), or by both such fine and imprisonment.	Effective

Oregon **Back To Top**	OR Revised Statute §163.165	A person commits the crime of assault in the third degree if the person intentionally, knowingly or recklessly causes physical injury to an emergency medical services provider, as defined in ORS 682.025, while the emergency medical services provider is performing official duties. Assault in the third degree is a Class C felony.	Effective
	OR Revised Statute §163.213	A person commits the crime of unlawful use of an electrical stun gun, tear gas or mace in the first degree if the person knowingly discharges or causes to be discharged any electrical stun gun, tear gas weapon, mace, tear gas, pepper mace or any similar deleterious agent against another person, knowing the other person to be a peace officer, corrections officer, parole and probation officer, firefighter or emergency medical services provider and while the other person is acting in the course of official duty. Unlawful use of an electrical stun gun, tear gas or mace in the first degree is a Class C felony.	Effective

Pennsylvania **Back To Top**	PA Consolidated Statutes Title 18 § 2702	A person is guilty of aggravated assault if he: (1) attempts to cause serious bodily injury to another, or causes such injury intentionally, knowingly or recklessly under circumstances manifesting extreme indifference to the value of human life; (2) attempts to cause or intentionally, knowingly or recklessly causes serious bodily injury to any of the officers, agents, employees or other persons enumerated in subsection (c) or to an employee of an agency, company or other entity engaged in public transportation, while in the performance of duty; (3) attempts to cause or intentionally or knowingly causes bodily injury to any of the officers, agents, employees or other persons enumerated in subsection (c), in the performance of duty; (4) attempts to cause or intentionally or knowingly causes bodily injury to another with a deadly weapon; (6) attempts by physical menace to put any of the officers, agents, employees or other persons enumerated in subsection (c), while in the performance of duty, in fear of imminent serious bodily injury; or (7) uses tear or noxious gas The officers, agents, employees and other persons referred to include emergency medical services personnel. The term includes, but is not limited to, doctors, residents, interns, registered nurses, licensed practical nurses, nurse aides, ambulance attendants and operators, paramedics, emergency medical technicians and members of a hospital security force while working within the scope of their employment. Aggravated assault under subsection (1) and (2) is a felony of the first degree. Aggravated assault under subsection (3), (4), (6) and (7) is a felony of the second degree.	Effective

Rhode Island **Back To Top**	RI General Laws §16-3-635	Any person who shall knowingly and willfully assault a health care provider and/or emergency medical services personnel while that provider is engaged in providing health care services shall be deemed to have committed a felony, and may be imprisoned no more than three (3) years and fined not more than fifteen hundred dollars ($1,500), or both.	Effective
South Carolina	N/A	Increased penalties for assault on emergency medical providers was repealed by 2010 Act No. 273, Section 7.A	Effective June 2010
South Dakota	SD CODIFIED LAWS § 22-11-6	Any person who, by using or threatening to use violence, force, or physical interference to intentionally obstruct emergency management personnel acting under color of authority, is guilty of obstructing an emergency medical technician. Obstructing a emergency medical technician is a Class 1 misdemeanor.	Effective
Tennessee	N/A	N/A	N/A

Texas **Back To Top**	TX PENAL CODE § 22.01	(a) A person commits an offense if the person: (1) intentionally, knowingly, or recklessly causes bodily injury to another, including the person's spouse; (2) intentionally or knowingly threatens another with imminent bodily injury, including the person's spouse; or (3) intentionally or knowingly causes physical contact with another when the person knows or should reasonably believe that the other will regard the contact as offensive or provocative. (b) An offense under Subsection (a)(1) is a Class A misdemeanor, except that the offense is a felony of the third degree if the offense is committed against: *** (5) a person the actor knows is emergency services personnel while the person is providing emergency services. *** (d) For purposes of Subsection (b), the actor is presumed to have known the person assaulted was a public servant, a security officer, or emergency services personnel if the person was wearing a distinctive uniform or badge indicating the person's employment as a public servant or status as a security officer or emergency services personnel. "Emergency medical personnel" means: (A) emergency care attendant; (B) emergency medical technicians; (C) emergency medical technicians-intermediate; (D) emergency medical technicians--paramedic; or (E) licensed paramedic.	Effective
	TX HB 705	Amends Texas Penal Code to raise assault against "emergency room personnel" to a felony of the third degree	Effective 9/1/13

Utah **Back To Top**	UT CODE § 76-5-102.7	(1) A person who assaults a health care provider or emergency medical service worker is guilty of a class A misdemeanor if: (a) the person knew that the victim was a health care provider or emergency medical service worker; and (b) the health care provider or emergency medical service worker was performing emergency or life saving duties within the scope of his authority at the time of the assault.	Effective
Vermont **Back To Top**	VT Statute Title 13 § 1028	(a) A person convicted of a simple or aggravated assault against a law enforcement officer, firefighter, emergency room personnel, or member of emergency services personnel as defined in subdivision 2651(6) of Title 24 while the officer, firefighter, or emergency medical personnel member is performing a lawful duty, in addition to any other penalties imposed under sections 1023 and 1024 of this title, shall: (1) For the first offense, be imprisoned not more than one year; (2) For the second offense and subsequent offenses, be imprisoned not more than ten years. (b) (1) No person shall intentionally cause blood, vomitus, excrement, mucus, saliva, semen, or urine to come in contact with a law enforcement officer while the officer is performing a lawful duty. (2) A person who violates this subsection shall be imprisoned not more than one year or fined not more than $ 1,000.00, or both. (c) In imposing a sentence under this section, the court shall take into consideration whether the defendant was a patient at the time of the offense and had a psychiatric illness, the symptoms of which were exacerbated by the surrounding circumstances, irrespective of whether the illness constituted an affirmative defense to the charge.	Effective

Virginia **Back To Top**	VA CODE § 18.2-51.1	If any person maliciously causes bodily injury to another by any means including the means set out in § 18.2-52, with intent to maim, disfigure, disable or kill, and knowing or having reason to know that such other person is an emergency medical services personnel, as defined in § 32.1-111.1 engaged in the performance of his public duties as emergency medical services personnel, such person shall be guilty of a felony punishable by imprisonment for a period of not less than five years nor more than 30 years and, subject to subsection (g) of § 18.2-10, a fine of not more than $ 100,000. Upon conviction, the sentence of such person shall include a mandatory minimum term of imprisonment of two years. If any person unlawfully, but not maliciously, with the intent aforesaid, causes bodily injury to another by any means, knowing or having reason to know such other person is emergency medical services personnel, engaged in the performance of his public duties as emergency medical services personnel, he shall be guilty of a Class 6 felony, and upon conviction, the sentence of such person shall include a mandatory minimum term of imprisonment of one year. "Emergency medical services personnel" means persons responsible for the direct provision of emergency medical services in a given medical emergency including all persons who could be described as attendants, attendants-in-charge, or operators.	Effective
	VA CODE § 18.2-57	Any person who commits a battery against another knowing or having reason to know that such individual is a health care provider as defined in § 8.01-581.1 who is engaged in the performance of his duties as an emergency health care provider in an emergency room of a hospital or clinic or on the premises of any other facility rendering emergency medical care is guilty of a Class 1 misdemeanor. The sentence of such person, upon conviction, shall include a term of confinement of 15 days in jail, two days of which shall be a mandatory minimum term of confinement.	Effective

Washington **Back To Top**	Revised Code WA § 9A.36.031	A person is guilty of assault in the third degree if he or she, under circumstances not amounting to assault in the first or second degree: Assaults a nurse, physician, or health care provider who was performing his or her nursing or health care duties at the time of the assault. For purposes of this subsection: "Nurse" means a person licensed under chapter 18.79 RCW; "physician" means a person licensed under chapter 18.57 or 18.71 RCW; and "health care provider" means a person certified under chapter 18.71 or 18.73 RCW who performs emergency medical services or a person regulated under Title 18 RCW and employed by, or contracting with, a hospital licensed under chapter 70.41 RCW. Assault in the third degree is a class C felony.	Effective

West Virginia **Back To Top**	WV CODE § 61-2-10B	(a) "Health care worker" means any nurse, nurse practitioner, physician, physician assistant or technician practicing at, and all persons employed by or under contract to a hospital, county or district health department, long-term care facility, physician's office, clinic or outpatient treatment facility. (b) Malicious assault. Any person who maliciously shoots, stabs, cuts or wounds or by any means causes bodily injury with intent to maim, disfigure, disable or kill a government representative or health care worker acting in his or her official capacity, and the person committing the malicious assault knows or has reason to know that the victim is acting in his or her official capacity is guilty of a felony and, upon conviction thereof, shall be confined in a correctional facility for not less than three nor more than fifteen years. (c) Unlawful assault. Any person who unlawfully but not maliciously shoots, stabs, cuts or wounds or by any means causes a government representative or health care worker acting in his or her official capacity bodily injury with intent to maim, disfigure, disable or kill him or her and the person committing the unlawful assault knows or has reason to know that the victim is acting in his or her official capacity is guilty of a felony and, upon conviction thereof, shall be confined in a correctional facility for not less than two nor more than five years.	Effective

West Virginia **Back To Top**	WV CODE § 61-2-10B Cont...	(d) Battery. Any person who unlawfully, knowingly and intentionally makes physical contact of an insulting or provoking nature with a government representative or health care worker acting in his or her official capacity, or unlawfully and intentionally causes physical harm to that person acting in such capacity, is guilty of a misdemeanor and, upon conviction thereof, shall be fined not more than $500 or confined in jail not less than one month nor more than twelve months or both fined and confined. If any person commits a second such offense, he or she is guilty of a felony and, upon conviction thereof, shall be fined not more than $1,000 or imprisoned in a state correctional facility not less than one year nor more than three years, or both fined and imprisoned. Any person who commits a third violation of this subsection is guilty of a felony and, upon conviction thereof, shall be fined not more than $2,000 or imprisoned in a state correctional facility not less than two years nor more than five years, or both fined and imprisoned. (c) Assault. Any person who unlawfully attempts to commit a violent injury to the person of a government representative or health care worker acting in his or her official capacity, or unlawfully commits an act which places that person acting in his or her official capacity in reasonable apprehension of immediately receiving a violent injury, is guilty of a misdemeanor and, upon conviction thereof, shall be confined in jail for not less than twenty-four hours nor more than six months, fined not more than two hundred dollars, or both fined and confined.	Effective

Wisconsin **Back To Top**	WI Statute § 940.20	(7) BATTERY TO EMERGENCY MEDICAL CARE PROVIDERS. *** (b) Whoever intentionally causes bodily harm to an emergency department worker, an emergency medical technician, a first responder or an ambulance driver who is acting in an official capacity and who the person knows or has reason to know is an emergency department worker, an emergency medical technician, a first responder or an ambulance driver, by an act done without the consent of the person so injured, is guilty of a Class H felony.	Effective
Wyoming	WY SF 114	(c) Aggravated assault and battery against a health care provider, as defined in W.S. 1-1-130(b)(i), who is engaged in providing health care services is a felony punishable by imprisonment for not more than twelve (12) years, a fine not more than five thousand dollars ($5,000.00), or both.	Approved by Senate but failed to get out of House before legislature adjourned

Attachment D

EMERGENCY NURSES ASSOCIATION of MICHIGAN

Mark Goldstein, RN, MSN, EMT-P I/C
SB 250 & SB 360 Testimony: 10/9/2013
96th Michigan Legislature

The Roller Coaster Ride of Assault Legislation—A Tale of the Ups and Downs in Texas

By Mary Leblond, MSN, RN, CEN, CA-CP, SANE, Member, ENA Government Affairs Committee

The Texas ENA State Council's legislative focus is to enhance the penalties for those who assault health care providers, which in Texas is currently a misdemeanor. At our instigation, during the 2011 legislative session, State Rep. Roland Gutierrez (D) introduced HB 703 to make it a felony to assault a health care provider.

However, wait. The mental health advocates were opposed to any escalating of penalties for assault. They were concerned that a patient suffering a psychiatric event could be charged with an assault and placed in a setting where he or she would not receive proper care and treatment.

A meeting with the TXENA, the Texas Nurses Association and the mental health proponents was arranged; the hope was that they would understand that health care providers are due the same protection under the law as police, firefighters and other emergency responders. After discussions and no foreseeable compromise, HB 703 was introduced at the Criminal Jurisprudence hearings with testimony in support from the TXENA, the TXNA and the Texas Hospital Association; the mental health advocates were in opposition. The bill sat in committee, pending a vote.

Sen. Kirk Watson introduced SB 295 proposing escalating penalties for assaulting emergency personnel. With a bill in the Senate and one in the House, one was bound to move forward. While SB 295 was for emergency personnel only, it represented an important step in the process. SB 295 headed to the Senate committee for a hearing, and it was not until the day of the hearing that the mental health advocates appeared to oppose the bill.

Testimony on the bill received the same support and opposition, and Watson called for a stakeholders meeting of both sides. Nine groups sat at the table discussing research statistics and concerns until a compromise was reached to amend SB 295 to protect mental health patients, provide education and training recommendations for emergency care personnel and determine when such individuals can initiate assault charges.

The Senate majority agreed to the compromise. The Senate-passed bill headed to the House Criminal Jurisprudence Committee, where the committee would decide if the bill would be a companion bill or if it would amend and pass the Senate bill.

Telephone calls, faxes, e-mails and legislative action alerts were sent and visits made to the members of the House committee until the bill was introduced. Five groups provided testimony with either support or no opposition, and only one mental health group opposed it. The end of the session neared. The bill needed to be on the House calendar for a vote in order to pass in the current legislative session.

The action alerts went out again. We waited. We anticipated. We heard the House committee passed the bill. It moved to the general calendar for a vote, but not before the last day of the House hearing for bills arrived.

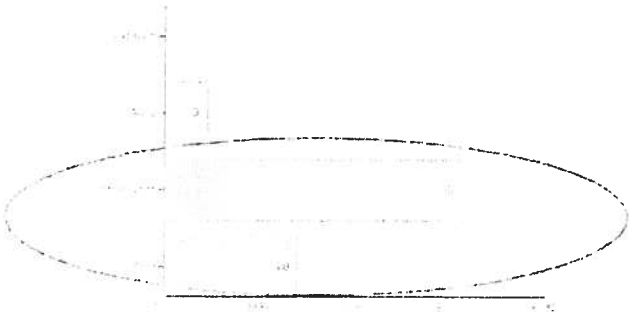
More e-mails and calls went out to the representatives. The bill was 57th on the House calendar. It was late in the day with many bills still to go. Bill No. 29 went to the House floor at 10:30 p.m. and debate began. At midnight, the session was called with No. 29 still being debated. We were so close.

At the TXENA state meeting, the TXENA Government Affairs Committee began to strategize, plan and prepare for the next legislative session. We know what we need to do. We know what we want. We now understand the opposition better. We will continue our fight to ensure that health care providers are provided safe working environments. Our goal is clearly in sight.

Feedback Frame

Members' views on the economy have shown little change since June 2009.

How would you describe the state of the nation's economy these days?



Attachment E

EMERGENCY NURSES ASSOCIATION of MICHIGAN

Mark Goldstein, RN, MSN, EMT-P I/C
SB 250 & SB 360 Testimony: 10/9/2013
96th Michigan Legislature

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Violence Against Nurses Working in US Emergency Departments

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Objective: The objective of this study was to investigate emergency nurses' experiences and perceptions of violence from patients and visitors in US emergency departments (EDs).

Background: The ED is a particularly vulnerable setting for workplace violence, and because of a lack of standardized measurement and reporting mechanisms for violence in healthcare settings, data are scarce.

Methods: Registered nurse members (n = 3,465) of the Emergency Nurses Association participated in this cross-sectional study by completing a 69-item survey.

Results: Approximately 25% of respondents reported experiencing physical violence more than 20 times in the past 3 years, and almost 20% reported experiencing verbal abuse more than 200 times during the same period. Respondents who experienced frequent physical violence and/or frequent verbal abuse indicated fear of retaliation and lack of support from hospital administration and ED management as barriers to reporting workplace violence.

Conclusion: Violence against ED nurses is highly prevalent. Precipitating factors to violent incidents identified by respondents is consistent with the research literature; however, there is considerable potential to mitigate these factors. Commitment from hospital administrators, ED managers, and hospital security is necessary to facilitate improvement and ensure a safer workplace for ED nurses.

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Workplace violence is a serious occupational risk for the domestic and global workforce,[1,2] accounting for approximately 900 deaths and 1.7 million nonfatal assaults each year in the United States.[3] In 2007, 15% of all work-related fatalities in the United States were due to assaults and violent acts.[4] Workplace violence may be even more common than these statistics indicate because a lack of a uniform definition of workplace violence,[5,6] incident underreporting,[6-9] and absence of mandated regulations for workplace violence prevention[5,9-15] make it difficult to assess the prevalence of workplace violence.[6] The National Institute for Occupational Safety and Health (NIOSH) defines workplace violence as an act of aggression directed toward persons at work or on duty, ranging from offensive or threatening language to homicide.[16] Workplace violence is generally defined as any physical assault, emotional or verbal abuse, or threatening, harassing, or coercive behavior in the work setting that causes physical or emotional harm.[5,14,16-19] In recent years, workplace violence has been recognized as a violent crime that requires targeted responses from employers, law enforcement, and the community.[19]

Barriers to Addressing Violence in the Healthcare Setting

Violent incidents in the workplace are often not reported to law enforcement authorities or employers.[3,7-9] Particularly in the healthcare industry, incidents may be underreported because of the absence of institutional reporting policies, the perception that assaults are part of the job, employee

beliefs that reporting will not benefit them, and employee concerns that assaults may be viewed as evidence of poor job performance or worker negligence.[6-9] In a study of nurses in the emergency department (ED), intensive care unit, and general units of a regional medical center, about 50% of the respondents indicated that verbal and physical assaults by patients and family members against nurses were never reported in writing.[8] Many nurses believed that such incidents were part of the job and reporting them would not be helpful. In addition, many felt that empathy for the anger expressed by the patient or family member and lack of evidence of personal physical injury were reasons for not reporting violent incidents.[8]

The Occupational Safety and Health Administration's[9] (OSHA's) *Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers* includes policy recommendations and practical methods to help prevent and reduce workplace violence. Because the guidelines are voluntary, some healthcare institutions may not have violence prevention programs in place or those that do may not have effective programs. To address the need for consistent and quality programs, nursing and other healthcare professional organizations and unions have asked for federal regulations that require healthcare institutions to provide improved environmental safety.[5,10,12,13,15]

Violence in the ED

In the hospital, violence occurs most frequently in psychiatric wards, EDs, waiting rooms, and geriatric units.[16] Studies have found that 35% to 80% of hospital staff have been physically assaulted at least once during their careers.[20] The high vulnerability to workplace violence in the hospital may be due, in part, to low staffing levels; lack of staff training in recognizing and defusing potentially dangerous patients; lack of violence prevention programs; inadequate security; the perception by criminals that hospitals, clinics, and pharmacies are sources of drugs and money; and possession of weapons by violent hospital patients and visitors.[5,9,12]

The 24-hour accessibility of EDs; the lack of adequately trained, armed, or visible security guards; and a highly stressful environment are some of the reasons why EDs are especially vulnerable to violence.[21-23] The overwhelming majority of perpetrators of ED violence are patients and their family members and visitors.[5,14-17] Patient pain and discomfort, as well as the tension, stress, and anger of patients, family members, and visitors, are often escalated by cramped space, lack of privacy, and long waiting times.[5,8,19,23] The resulting frustration and vulnerability may incite physical and verbal abuse against ED staff.[16,19,22] In addition, verbal abuse and physical assault in the ED can come from disruptive, intoxicated patients who are sometimes accompanied by other intoxicated or disruptive individuals.[7,21]

Violence Against Nurses

Nursing has received increasing attention as an occupation at high risk for violent attacks.[2,5,7,9-11,19,22-26] The National Crime Victimization Survey (1993-1999) found that the average annual rate for nonfatal violent crime was 21.9 per 1,000 workers for nurses, compared with only 12.6 per 1,000 workers for all occupations.[3] According to the Bureau of Labor Statistics,[27] in 2004, 46% of nonfatal assaults and violent acts against healthcare practitioners that involved days off work were committed against registered nurses (RNs). Nursing staff are primary targets of violence in the ED.[15,17] In one study, 82% of emergency nurses indicated that they had been physically assaulted at work during the preceding year.[8] The incidence of verbal abuse is increasing as well, and such abuse affects 100% of emergency nurses in some facilities.[6,8,26]

The American Nurses Association found that less than 20% of nurses surveyed in 2001 felt safe in their current work environment.[28] Research has consistently found that nurses are concerned about violence and aggression, inadequate safety measures, and personal vulnerability in the workplace.[7,8,13,26,29] Many nurses simply do not feel safe at work.[8,26,28] A perceived lack of institutional support is a key factor in the dissatisfaction that nurses feel.[8,13] This sense of administrative abandonment may result from inadequate staffing levels, unfulfilled promises to improve environmental safety, ignored concerns, insufficient education and training, and lack of support from peers, physicians, and administrators in the aftermath of an incident.[13] Fair and consistent procedures and a culture of support, not punishment, for victims are critical.[6,19,30]

The Need for Institutional Initiatives

As assaults in the ED continue to be a serious problem, interventions and preventive measures are urgently needed.[2,5,9,12,31] A significant amount of workplace aggression is preventable.[18] Lack of a violence prevention program, for example, is associated with an increased assault risk in hospitals.[5,9] A strong, comprehensive violence prevention program requires an interdisciplinary team approach with clear goals and objectives suitable for the size and complexity of the workplace.[9,10,12,16,19] The OSHA recommends a violence prevention program

that includes management commitment and employee involvement, worksite analysis of existing or potential hazards for workplace violence, measures for violence hazard prevention and control, safety and health training for staff, and record keeping and program evaluation to determine program effectiveness.[5,9,12] The NIOSH also delineates prevention strategies for reducing exposure to violence risk factors in hospitals, including environmental designs to provide a safe workplace, administrative controls to ensure safe staffing patterns and adequate security measures, and training workers to recognize and manage potential assaults.[16]

Study Objective

Because of the lack of standardized measurement and reporting mechanisms for workplace violence in the healthcare industry,[15] data are scarce, necessitating the need for research that explores violence against emergency nurses.[6-8,14,15,17,19,21,22,26,29,32] The Emergency Nurses Association (ENA) was charged by its membership to address violence against ED nurses through advocacy and research. In response, this study was conducted to investigate emergency nurses' experiences and perceptions of ED violence, the types and frequencies of assaults in the ED, and contributing factors to ED violence (See Presentation, Supplemental Digital Content 1, which presents an overview of the study, http://links.lww.com/A1415). To view a PowerPoint presentation given at the ENA 2008 Annual Conference, go to http://www.ena.org/conferences/annual/2008/handouts/339-C.pdf.

Methods

This cross-sectional study was conducted by ENA, a nonprofit association of approximately 31,905 US members at the time the study was conducted. A survey about workplace violence was developed by an ENA work team, evaluated by experts for content validity, and pilot tested on a sample of 15 emergency nurses. The 69-item online survey concerned the respondent's personal experience with physical violence and verbal abuse in the ED, the policies and procedures of the respondent's hospital and ED for addressing workplace violence, and the respondent's beliefs about the precipitating factors of violence and barriers to reporting violence in the ED.

A convenience sampling strategy was used. All ENA members who were RNs working in US EDs at the time of the survey and who had Internet access were eligible to participate in the study. The online survey was developed using Survey Select Expert (version 5.6). The 1-time survey was accessible online during the spring of 2007 for 1 month. Participation was solicited through ENA newsletters, the Web site, and e-mail announcements during the same period. Although ENA could not restrict multiple submissions by the same nurse, the length of the survey may have served as a deterrent. Institutional review board approval for the study was obtained from Chesapeake Research Review, Inc, and designated as exempt.

SPSS Windows (version 14) was used for data management and statistical analysis. Because the data had statistically nonnormal distributions, nonparametric statistical methods were used to analyze the data. Nurses whose responses indicated that they had experienced a high frequency of physical violence (>20 times) from patients/visitors in the ED during the past 3 years were classified as frequent-physical-violence-experience (FPVE) nurses. Nurses whose responses indicated that they had experienced a high frequency of verbal abuse (>200 times) from patients/visitors during the past 3 years were classified as frequent-verbal-abuse-experience (FVAE) nurses. The χ^2 test of association and Fisher exact test (when expected frequencies were too small to permit use of the χ^2 test) were used to compare independent groups with respect to percentages. The Kruskal-Wallis and Mann-Whitney U tests were used to compare independent groups with respect to noncategorical variables. For all statistical analyses, a .05 significance level was used. No 1-sided tests were done. Data are presented as mean ± SD.

Results

A total of 3,465 (10.9%) emergency nurses completed the survey. This sample of nurses was representative of all 50 states and the District of Columbia. Table 1 describes the characteristics of the respondents and the EDs and facilities at which they worked. The overwhelming majority (87.4%) worked in general EDs, 63.6% worked in a trauma center, 59.7% worked as staff nurses, and 52.1% primarily worked the day shift. The mean ± SD nursing experience was 16.5 ± 10.7 years, emergency nursing experience was 12.1 ± 8.8 years, and experience in the respondent's current ED was 7.6 ± 7.2 years. Most respondents (84.4%) were women.

Some of the most common types of physical violence experienced by more than 50% of respondents were "spit on," "hit," "pushed/shoved," "scratched," and "kicked." In terms of verbal abuse, 70% or more of respondents experienced being "yelled/cursed at," "intimidated," and "harassed with sexual language/innuendo." Sixty-seven percent rated

Table 1. Characteristics of Emergency Nurses and the Emergency Departments (EDs)/Facilities at Which They Worked

Characteristic[a]	% (n)
Emergency nurses	
Sex (n = 3,446)	
Female	84.4 (2,910)
Male	15.6 (536)
Age, y (n = 3,451)	
18-24	1.7 (58)
25-34	17.7 (612)
35-44	29.6 (1,022)
45-54	38.2 (1,317)
≥55	12.8 (442)
RN role (n = 3,461)	
Staff nurse	59.7 (2,066)
Charge nurse	16.1 (556)
ED manager	11.0 (379)
Clinical/staff educator	4.9 (169)
Clinical nurse specialist	1.3 (44)
Administrator/director	1.2 (42)
Nurse practitioner	1.0 (33)
Other	5.0 (172)
Shift primarily worked (n = 3,452)	
Day	52.1 (1,798)
Night	25.7 (888)
Evening	13.0 (448)
Rotating	9.2 (318)
Days primarily worked (n = 3,434)	
Weekdays	21.9 (752)
Weekends	7.4 (255)
Both weekdays and weekends	70.7 (2,427)
EDs/facilities	
ED type (n = 3,460)	
General	87.4 (3,025)
Adult only	8.9 (308)
Pediatric only	3.7 (127)
Community population (n = 3,262)	
≤10,000	10.0 (325)
10,001-30,000	16.7 (545)
30,001-100,000	27.1 (884)
100,001-500,000	27.0 (881)
≥500,001	19.2 (627)
Facility type (n = 3,447)	
Nongovernment, not-for-profit	69.5 (2,397)
Investor owned, for-profit	19.1 (657)
State or local government	9.0 (310)
Federal government, military, or Veterans Affairs	2.4 (83)

[a]Sample size fluctuates because of missing data.

their perception of safety at 5 or below on a 10-point scale (1, not at all safe to 10, extremely safe). One-third had considered leaving their ED or emergency nursing because of ED violence.

Frequent Physical Violence Experience

Twenty-three percent (n = 811) of respondents were FPVE nurses. Table 2 describes the factors found to be related to FPVE. As expected, nurses in pediatric EDs were less likely to experience frequent physical violence, whereas nurses who primarily worked the night shift and nurses who worked on weekends were more likely to experience frequent physical violence. Female nurses were less likely than male nurses to indicate that they had experienced frequent physical violence. A reduced risk of experiencing frequent physical violence in the ED was associated with having facility policies for reporting workplace violent incidents, facility responses to such incidents, and hospital and ED administration commitment to eliminating workplace violence against emergency nurses. Nurses who felt that violence from patients/visitors is an unavoidable part of practice were more likely to have experienced frequent ED physical violence.

The following barriers to reporting ED violent incidents were associated with an increased risk of experiencing frequent physical violence in the ED: the perception that reporting ED violent incidents might have a negative effect on customer service scores/reports; ambiguous ED violence reporting policies; fear of retaliation from ED management, hospital administration, nursing staff, or physicians for reporting ED violent incidents; failure of staff to report ED violent incidents; the perception that reporting ED violent incidents was a sign of incompetence or weakness; lack of physical injury to staff; the attitude that violence comes with the job; and lack of support from administration/management. Nurses who felt that there were no barriers to reporting ED violent incidents were much less likely to have experienced frequent ED physical violence (ie, >20 times in the last 3 years) than were other nurses: 15.4% versus 28.5% ($P < .001$).

Nurses also were asked whether 29 factors precipitated workplace violence against RNs in their EDs. The precipitating factors listed in the survey were identified through a review of the research literature and input from emergency nurse content experts. Table 3 lists the most important factors (those specified by >50% of nurses). The factors that can potentially be altered by the ED or facility were: care of psychiatric patients in the ED, crowding/high patient volume, prolonged wait times, misconception by patients or visitors of staff behavior (such as nurses laughing), patients' or visitors' perception that staff is uncaring, holding or boarding patients, shortage of ED RNs, no or poorly enforced visitor policy, and care of patients with dementia or Alzheimer disease in the ED. Nurses in the FPVE group were significantly more likely than those in the non-FPVE group to perceive all but 4 of the 29 factors as precipitators of ED violence.

Frequent Verbal Abuse Experience

Similar results were obtained for verbal abuse. Almost 20% (n = 604) of respondents were FVAE

Table 2. Factors Related to Experience of Frequent Physical Violence by Emergency Nurses

Factor[a]	Non-FPVE Nurses, %[b] (n)	FPVE Nurses, %[b] (n)	*P*
Sex (n = 3,043)			<.001
Female	74.8 (1,908)	25.2 (643)	
Male	66.9 (329)	33.1 (163)	
ED type (n = 3,056)			<.001
Pediatric only	90.8 (99)	9.2 (10)	
Adult only or general	72.9 (2,149)	27.1 (798)	
Shift primarily worked (n = 3,050)			.002
Day	76.1 (1,214)	23.9 (382)	
Evening	72.1 (289)	27.9 (112)	
Night	68.7 (540)	31.3 (246)	
Rotating	74.2 (198)	25.8 (69)	
Days primarily worked (n = 3,033)			.001
Weekdays	78.9 (525)	21.1 (140)	
Weekends	72.1 (160)	27.9 (62)	
Both weekdays and weekends	71.9 (1,563)	28.1 (603)	
Facility policy for reporting workplace violent incidents (n = 2,534)			<.001
Present	74.4 (1,602)	25.6 (551)	
Absent	63.8 (243)	36.2 (138)	
No facility response to workplace violent incidents (n = 3,060)			<.001
Yes	63.0 (308)	37.0 (181)	
No	75.5 (1,941)	24.5 (630)	
Hospital administration committed to eliminating workplace violence against emergency nurses (n = 3,043)			<.001
Yes	82.6 (737)	17.4 (155)	
No	69.7 (1,500)	30.3 (651)	
ED management committed to eliminating workplace violence against emergency nurses (n = 3,047)			<.001
Yes	77.9 (1,226)	22.1 (348)	
No	68.8 (1,013)	31.2 (460)	
Feel that violence from patients/visitors is part of practice (n = 3,048)			<.001
Yes	67.8 (1,004)	32.2 (476)	
No	78.8 (1,236)	21.2 (332)	
Barriers to reporting ED violent incidents			
Reporting ED violent incidents might affect customer service scores/reports (n = 3,060)			<.001
Yes	68.2 (763)	31.8 (355)	
No	76.5 (1,486)	23.5 (456)	
Ambiguous ED violence reporting policies (n = 3,060)			<.001
Yes	69.1 (635)	30.9 (284)	
No	75.4 (1,614)	24.6 (527)	
Fear of retaliation from ED management for reporting ED violent incidents (n = 3,060)			<.001
Yes	63.6 (295)	36.4 (169)	
No	75.3 (1,954)	24.7 (642)	
Fear of retaliation from hospital administration for reporting ED violent incidents (n = 3,060)			<.001
Yes	66.5 (468)	33.5 (236)	
No	75.6 (1,781)	24.4 (575)	
Fear of retaliation from nursing staff for reporting ED violent incidents (n = 3,060)			.007
Yes	63.4 (83)	36.6 (48)	
No	74.0 (2,166)	26.0 (763)	
Fear of retaliation from physicians for reporting ED violent incidents (n = 3,060)			.008
Yes	63.8 (88)	36.2 (50)	
No	74.0 (2,161)	26.0 (761)	
No one reports ED violent incidents (n = 3,060)			<.001
Yes	68.2 (503)	31.8 (235)	
No	75.2 (1,746)	24.8 (576)	
Reporting ED violent incidents perceived as a sign of incompetence (n = 3,060)			.002
Yes	68.0 (344)	32.0 (162)	
No	74.6 (1,905)	25.4 (649)	

Table 2. Continued

Factor[a]	Non-FPVE Nurses, %[b] (n)	FPVE Nurses, %[b] (n)	*P*
Reporting ED violent incidents perceived as a sign of weakness (n = 3,060)			.037
Yes	70.2 (428)	29.8 (182)	
No	74.3 (1,821)	25.7 (629)	
Lack of physical injury to staff (n = 3,060)			.040
Yes	71.5 (894)	28.5 (356)	
No	74.9 (1,355)	25.1 (455)	
Attitude that violence comes with the job (n = 3,059)			<.001
Yes	64.8 (608)	35.2 (330)	
No	77.3 (1,640)	22.7 (481)	
Lack of support from administration/management (n = 3,060)			.003
Yes	63.6 (105)	36.4 (60)	
No	74.1 (2,144)	25.9 (751)	

Abbreviations: ED, emergency department; FPVE, frequent physical violence experience.
[a]Sample size fluctuates because of χ^2 analyses and missing data.
[b]Row percentages.

nurses. Factors related to FVAE are shown in Table 4. Nurses were more likely to experience frequent verbal abuse if they worked in general or adult-only EDs, primarily worked the night shift, or worked on weekends. Female nurses were slightly less likely than male nurses to indicate that they had experienced frequent verbal abuse. Facility policies for reporting workplace violent incidents, facility responses to such incidents, and hospital and ED administration commitment to eliminating workplace violence against emergency nurses were all associated with a reduced risk of experiencing frequent verbal abuse. Barriers to reporting ED violent incidents were often associated with an increased risk of experiencing frequent verbal abuse. Nurses who felt that there were no barriers to reporting ED violent incidents were much less likely to have experienced frequent ED verbal abuse (ie, >200 times in the last 3 years) than were other nurses: 9.78% versus 21.5% ($P < .001$).

Strategies and Interventions

The effectiveness of strategies such as security, environmental controls, and violence prevention education/training cannot be determined from cross-sectional data of this type because such strategies are often initiated in EDs after violence becomes a problem. This confounding can make it appear as if such strategies increase ED violence. For example, nurses who indicated that their hospital had no security personnel were significantly less likely to have experienced frequent physical violence ($P = .002$) or frequent verbal abuse ($P = .007$) than were other nurses. However,

Table 3. FPVE and Non-FPVE Nurses' View of Factors Related to ED Violence

Factor	Perceived as Precipitator of ED Violence, % (n)			*P*
	Total Sample	FPVE Group	Non-FPVE Group	
Patients/visitors under influence of alcohol	90.2 (3,126)	94.7 (768)	90.0 (2,023)	<.001
Drug-seeking behavior	90.2 (3,124)	94.0 (762)	89.4 (2,010)	<.001
Patients/visitors under influence of illicit drugs	88.4 (3,063)	94.3 (765)	87.7 (1,972)	<.001
Care of psychiatric patients in ED	88.2 (3,055)	91.9 (745)	86.7 (1,950)	<.001
Crowding/high patient volume	87.0 (3,015)	91.1 (739)	86.5 (1,945)	.001
Prolonged wait times	83.5 (2,892)	86.3 (700)	84.0 (1,890)	NS
Misconception by patients/visitors of staff behavior	66.1 (2,289)	69.7 (565)	65.9 (1,481)	.048
Patients/visitors' perception that staff is uncaring	65.6 (2,272)	71.8 (582)	64.6 (1,452)	<.001
Holding/boarding patients	59.1 (2,048)	68.3 (554)	56.3 (1,267)	<.001
Shortage of ED RNs	58.6 (2,031)	66.2 (537)	55.8 (1,256)	<.001
No/poorly enforced visitor policy	56.2 (1,949)	69.1 (560)	52.9 (1,189)	<.001
Care of patients with dementia/Alzheimer disease in ED	54.6 (1,893)	59.1 (479)	53.8 (1,209)	.009

Abbreviations: ED, emergency department; FPVE, frequent physical violence experience; NS, not statistically significant.

Table 4. Factors Related to Experience of Frequent Verbal Abuse by Emergency Nurses

Factor[a]	Non-FVAE Nurses, % (n)	FVAE Nurses, % (n)	P
Sex (n = 3,048)			.045
Female	80.9 (2,065)	19.1 (488)	
Male	77.0 (381)	23.0 (114)	
ED type (n = 3,060)			.034
Pediatric only	88.2 (97)	11.8 (13)	
Adult only or general	80.0 (2,360)	20.0 (590)	
Shift primarily worked (n = 3,055)			.001
Day	82.8 (1,317)	17.2 (274)	
Evening	77.5 (306)	22.5 (89)	
Night	76.1 (606)	23.9 (190)	
Rotating	81.7 (223)	18.3 (50)	
Days primarily worked (n = 3,039)			.012
Weekdays	83.8 (560)	16.2 (108)	
Weekends	76.0 (174)	24.0 (55)	
Both weekdays and weekends	79.5 (1,795)	20.5 (440)	
Facility policy for reporting workplace violent incidents (n = 2,536)			<.001
Present	81.7 (1,767)	18.3 (395)	
Absent	71.9 (269)	28.1 (105)	
No facility response to workplace violent incidents (n = 3,064)			<.001
Yes	71.5 (353)	28.5 (141)	
No	82.0 (2,107)	18.0 (463)	
Hospital administration committed to eliminating workplace violence against emergency nurses (n = 3,047)			<.001
Yes	88.5 (799)	11.5 (104)	
No	76.8 (1,647)	23.2 (497)	
ED management committed to eliminating workplace violence against emergency nurses (n = 3,052)			<.001
Yes	84.0 (1,325)	16.0 (253)	
No	76.2 (1,123)	23.8 (351)	
Barriers to reporting violent incidents			
Reporting ED violent incidents might affect customer service scores/reports (n = 3,064)			<.001
Yes	75.0 (834)	25.0 (278)	
No	83.3 (1,626)	16.7 (326)	
Ambiguous ED violence reporting policies (n = 3,064)			<.001
Yes	76.1 (687)	23.9 (216)	
No	82.0 (1,773)	18.0 (388)	
Fear of retaliation from ED management for reporting ED violent incidents (n = 3,064)			<.001
Yes	72.7 (335)	27.3 (126)	
No	81.6 (2,125)	18.4 (478)	
Fear of retaliation from hospital administration for reporting ED violent incidents (n = 3,064)			<.001
Yes	74.6 (523)	25.4 (178)	
No	82.0 (1,937)	18.0 (426)	
Inconvenient/do not want to deal with it (n = 3,064)			.001
Yes	77.2 (873)	22.8 (258)	
No	82.1 (1,587)	17.9 (346)	
No one reports ED violent incidents (n = 3,064)			<.001
Yes	75.0 (548)	25.0 (183)	
No	82.0 (1,912)	18.0 (421)	
Reporting ED violent incidents perceived as a sign of incompetence (n = 3,064)			<.001
Yes	74.6 (379)	25.4 (129)	
No	81.4 (2,081)	18.6 (475)	
Reporting ED violent incidents perceived as a sign of weakness (n = 3,064)			<.001
Yes	74.0 (444)	26.0 (156)	
No	81.8 (2,016)	18.2 (448)	
Lack of physical injury to staff (n = 3,064)			<.001
Yes	76.6 (951)	23.4 (290)	
No	82.8 (1,509)	17.2 (314)	
Attitude that violence comes with the job (n = 3,063)			<.001
Yes	73.6 (680)	26.4 (244)	
No	83.2 (1,779)	16.8 (360)	

Table 4. Continued

Factor[a]	Non-FVAE Nurses, %[b] (n)	FVAE Nurses, %[b] (n)	*P*
Lack of support from administration/management (n = 3,064)			<.001
Yes	65.4 (106)	34.6 (56)	
No	81.1 (2,354)	18.9 (548)	

Abbreviations: ED, emergency department; FVAE, frequent verbal abuse experience.
[a]Sample size fluctuates because of χ^2 analyses and missing data.
[b]Row percentages.

as evidenced by nurses' comments in the survey, having inadequate security personnel to effectively mitigate violence was a major concern.

Limitations

As is true for most studies based on self-report, this study is limited by the potential inaccuracy of self-reported data. No self-report study can conclusively identify factors related to ED violence. Because a convenience sampling method was used and all respondents were ENA members, the generalizability of the study is limited. Despite these limitations, the results indicate the extent and severity of workplace violence experienced by emergency nurses and the substantial barriers that remain to preventing, mitigating, and reporting ED violence. Opportunities to address these barriers exist. Further research is needed to identify best practices for preventing and mitigating ED violence.

Discussion

As the first national study of emergency nurses' experiences and perceptions of workplace violence, this study provides significant contributions to our understanding of ED violence. As evident from the survey findings, workplace violence is highly prevalent among the ED nurses in our study, highlighting the seriousness of the issue. Findings from this study are consistent with the research literature involving nurses in other disciplines and emergency nurses internationally. Our findings further support the research literature in that nurses indicated not feeling safe in the workplace, a perception that violence is an unavoidable aspect of the job, barriers to reporting violence, a desire for improved security measures, and a lack of administrative commitment to addressing ED violence.

The results of this study have important implications for strategies to reduce ED violence. Innovative approaches are needed to modify factors that emergency nurses believe are precipitators of ED violence, such as care of psychiatric patients in the ED, crowding, long wait times, misconceptions of staff behavior, perceptions of staff as uncaring, holding/boarding patients, shortage of nurses, and lack of an enforced visitor policy. These are well-known ED problems, and the solutions are difficult, hence the need for innovation. In addition, there is a need to change hospital administration's and emergency nurses' perceptions and attitudes that violence is acceptable and "comes with the job." Reducing ED violence will require solving many of the larger problems that afflict EDs, some of which originate outside the ED at the hospital or community level.

As indicated by the nurses in this study, a strong administrative commitment is imperative to reducing ED violence and eliminating barriers to reporting incidents of violence. Staff and ED managers need to know that senior administrators are aware of the violence issue and support efforts to prevent and mitigate violence. Nurse executives must be proactive in taking steps to make the workplace safe. Establishing a culture of acceptance for reporting violent incidents is a positive step toward creating a safer work environment. Procedures for reporting violent incidents should be clear and consistent, and ED staff should have access to medical care and follow-up counseling if needed. Another essential strategy to addressing ED violence is convening an interdisciplinary task force to identify vulnerabilities in the ED and develop a plan for preventing, mitigating, responding to, and reporting violence. This task force should include the chief operating officer, chief nurse executive, ED medical director, ED manager/director, security personnel, risk management personnel, local police, and most importantly, ED nurses.

Findings from the study were inconclusive regarding the effectiveness of education and training on violence prevention; however, many hospitals provide violence prevention education for ED staff.

Education should include practical and relevant skills for managing assaultive behavior in the ED. For example, education for ED managers and staff should include learning how to be aware of one's surroundings and identify patients and visitors who may be disposed toward violent behavior.

Conclusion

The recommendations outlined here involve facility and department level change for improving workplace safety. This study is one important step toward identifying ways to mitigate and respond to ED violence. Additional research to further this cause should focus on the effectiveness of education in preparing nurses to deescalate a potentially violent situation, the usefulness of various security measures and environmental controls, best practices for reducing ED violence, and longitudinal trending of ED violence incidence and prevalence rates.

More importantly, federal and state laws to protect ED nurses from violence are needed to address this issue. Whereas some states have made assault of a nurse a felony, other states do not have such stringent laws in place to adequately protect nurses. Unfortunately, legislation such as this is often passed only after a tragic incident against a nurse takes place. To make this a legislative priority, leaders of nursing organizations need to use their government affairs departments to heighten legislators' awareness. Without legislative action at the state and federal level and innovative strategies at the hospital and department level, there can be no realistic hope of significantly decreasing ED violence.

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Attachment F

EMERGENCY NURSES ASSOCIATION of MICHIGAN

Mark Goldstein, RN, MSN, EMT-P I/C
SB 250 & SB 360 Testimony: 10/9/2013
96th Michigan Legislature

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JOURNAL OF NURSING SCHOLARSHIP

CLINICAL SCHOLARSHIP

Violence Toward Nurses, the Work Environment, and Patient Outcomes

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Key words
Violence, work environment, patient outcomes, medical/surgical nursing

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Abstract

Purpose: To relate nurses' self-rated perceptions of violence (emotional abuse, threat, or actual violence) on medical-surgical units to the nursing working environment and to patient outcomes.

Design: Cross-sectional collection of data by surveys and primary data collection for 1-week periods on 94 nursing wards in 21 hospitals in two states of Australia.

Methods: Nursing Work Index-Revised (NWI-R); Environmental Complexity Scale (ECS) PRN-80 (a measure of patient acuity); and a nursing survey with three questions on workplace violence; combined with primary data collection for staffing, skill mix, and patient outcomes (falls, medication errors).

Findings: About one third of nurses participating (N= 2,487, 80.3% response rate) perceived emotional abuse during the last five shifts worked. Reports of threats (14%) or actual violence (20%) were lower, but there was great variation among nursing units with some unit rates as high as 65%. Reported violence was associated with increased ward instability (lack of leadership; difficult MD and RN relationships). Violence was associated with unit operations: unanticipated changes in patient mix; proportion of patients awaiting placement; the discrepancy between nursing resources required from acuity measurement and those supplied; more tasks delayed; and increases in medication errors. Higher skill mix (percentage of registered nurses) and percentage of nurses with a bachelor of science in nursing degrees were associated with fewer reported perceptions of violence at the ward level. Intent to leave the present position was associated with perceptions of emotional violence but not with threat or actual assault.

Conclusions: Violence is a fact of working life for nurses. Perceptions of violence were related to adverse patient outcomes through unstable or negative qualities of the working environment. Perceptions of violence affect job satisfaction.

Clinical Relevance: In order to manage effectively the delivery of nursing care in hospitals, it is essential to understand the complexity of the nursing work environment, including the relationship of violence to patient outcomes.

The popular press provides a picture of a decline in basic societal civility. Bullying is discovered in primary schools and on the Internet, and rudeness is all too often the order of the day in service negotiations. Front-line service professions such as policing, teaching, and nursing are especially targets for interpersonal violence. Violence can take many forms, including verbal and emotional abuse; physical assault; threats of physical violence; unwanted sexual advances; and harassment. In nursing, it can arise from patients, patients' families, visitors, or colleagues. Nurses in emergency departments (EDs), inpatient psychiatric units, and nursing homes have been thought to be particularly vulnerable.

An unsafe working environment is detrimental to nurses' ability to deliver safe, quality care. This paper reports data on nurses' perceptions of violence in inpatient medical/surgical nursing settings in 94 nursing wards in 21 hospitals in Australia. Violence in inpatient medical/surgical settings, which is where the majority of nurses work, has not been widely studied, nor has the perception of violence among nurses been linked to variables in the working environment or patient outcomes.

Review of Literature

The World Health Organization (WHO) has defined violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation" (WHO, 2002, p. 5). WHO has produced guidelines for dealing with violence in the workplace (Wiskow, 2003).

Violence from relatives and friends of patients may occur as a result of frustration with a perceived lack of care or communication. For example, Lyneham (2001) discussed how relatives waiting with their loved one to be seen in EDs may initiate this behavior. Pain, anxiety, loss of control, powerlessness, and disorientation may result in aggressive incidents from patients to nurses (Ferns, 2007). Sometimes the tasks nurses must do may initiate or exacerbate these feelings and precipitate violent outbursts. Some have observed that experienced nurses are more likely to preempt situations that may lead to violence (Ferns, 2007; Royal College of Psychiatrists, 1998). For example, offering regular pain relief medication can avoid deterioration and discomfort that may manifest as aggression. Specialized nurses may have learned how to predict violence, especially in patients with brain injuries or those with psychiatric problems (Royal College of Psychiatrists, 1998). In the United States, some hospitals have implemented a "code" for violence that evokes a response like that of a rapid response team (Jacobson, 2007).

Kingma (2001) proposed that the societal tolerance of violence toward nurses might extend to nurses themselves, who may feel that a degree of violence is "part of the job." Duxbury (2003) found that nurses attributed patient-related violence to patients' treatment states. Nurses who felt that their managers were not able to improve the situation felt powerless (Chambers, 1998). The effects of violence can spread distress among staff, patients, family, and friends, and if there is no active management of the incident, there can be lasting damage (WorkSafe Western Australia Commission, 1999).

Rowe and Sherlock (2005) studied verbal abuse in nursing—"eating our young." They concluded that bullying of this form is costly to the individual nurse, erupting as job stress, job dissatisfaction, missed work, and perhaps decreased quality of patient care. Farrell (1997), in a qualitative study of 29 nurses' experiences of aggression, found that "horizontal violence" was more distressing to nurses than physical assault from patients. SANE, the national mental health charity in Australia (SANE, 2004), suggested that some health professionals who are perpetrators of this aggression may themselves be suffering from a mental illness. Dellasega's (2009) review of bullying in nursing notes that most of the bullying literature comes from non-U.S. studies. The cost of violence in the workplace is important as it can lead to a deterioration in staff health (Grenyer et al., 2004; Rees & Lehane, 1996) and an increased nurse turnover rate (Jackson, Clare, & Mannix, 2002; Stevens, 2002). A U.K. report (National Audit Office, 2003) estimated that workplace violence cost the National Health Service (NHS) £69 million a year (US$98 million). In the United States it is difficult to calculate an accurate cost as only 20% of private industry and only up to 36% of government establishments track the cost of incidents related to violence (Bureau of Labor Statistics, 2005). In Australia, the government estimated the figure for workplace violence at $6–13 billion nationwide per year (Queensland Government, 2002). This figure would include all kinds of workplace violence, not just that which is associated with nursing. In the United Kingdom, up to 37% of sick leave costs were related to violence and aggression (Rose, 1997).

There is an alarming reluctance of nurses to report violence in the workplace. Lyneham (2000) reported over 70% of incidents in New South Wales, Australia, hospital EDs were not referred to authorities. In the United Kingdom this phenomenon has led to change management strategies to improve the work environment (Ferns & Chojnacka, 2005). In Ireland, Rose (1997) reported that 29% of nurses had not reported their latest physical assault, and most verbal abuse was not reported at

all. It was suggested that nurses felt reporting was an empty gesture, with a general lack of support for the nurse victims. Nurses may not access support for violent incidents in the workplace because they feel it is wrong to be seen to need support, which is interpreted as professional failure (Paterson, Leadbetter, & Bowie, 1999). In certain areas of practice such as mental health, lack of reporting can occur because nurses may become complacent when faced with verbal abuse—it is just part of the job (Royal College of Psychiatrists, 2007). Grenyer et al. (2004) found that staff became more confident in dealing with aggressive behavior after attending aggression minimization in-service programs. The submission from the Council of Deans of Nursing and Midwifery (Australia and New Zealand; 2005) to the Australian Government Productivity Commission Health Workforce Study stated that inadequate managerial care after violent incidents may lead to a reduction in nurses' proficiency, which then has negative implications for patient care.

Evidence of the consequences to healthcare professionals who report incompetent, unethical, or illegal practices in the workplace (whistleblowers) is limited. A survey of nurses in Western Australia found that nurses who reported incompetence or illegal practice suffered consequences such as official reprimands, demotion, and referral to a psychiatrist, together with personal threats and pressure to resign (McDonald & Aherne, 2000). Of the many theories suggesting why violence is underreported in the workplace (Farrell, 2001), one interpretation is that nurses do not wish to be disloyal to colleagues. Regardless, a lack of reporting contributes to the issue remaining poorly recognized (Hockley, 2000).

Epidemiology of Violence Toward Nurses

The majority of the literature on violence in nursing deals with EDs, psychiatric settings, or nursing homes, all thought to have higher rates of violence than other types of practice environments. The literature reviewed here is, where possible, that which relates to our focus on medical-surgical settings.

In a study of policy implications and recent trends in the international migration of nurses, Buchan, Kingma, and Lorenzo (2005) reported that nurses are three times more likely to be the victims of violence than other health personnel. Foster, Bowers, and Nijman (2007) calculated that in any given 12-month period, nurses working in acute psychiatric units in the United Kingdom had a 1 in 10 chance of receiving an injury as a result of patient aggression, while Wells and Bowers (2002), also in the United Kingdom, found a similar rate of violence (with or without injury) against general nurses. In addition, one NHS Trust found that nurses caring for the elderly were more likely (65% vs. 42%) to experience an incident of violence or aggression than occupational therapists or physiotherapists (Mullan & Badger, 2007).

In a report for the Royal College of Nursing, Australia, Rumsey, Foley and Dakin (2007, p. 2) stated that violence, bullying and harassment were "major concerns" to nurses in that country and that there is an underestimated psychological and economic impact on nurses. In their fact sheet, the International Council of Nurses (2008) described the problem as a "world-wide epidemic."

In Australia, 40% of nurses in metropolitan EDs and 30% in rural hospital EDs in New South Wales experienced some type of violence or assault each month (Lyneham, 2001). Lyneham (2000) found this was almost a daily occurrence in EDs and that nurses had concerns about their safety relating to the workplace layout, lack of security equipment, and staff. In Tasmania, Australia, 64% of 6,326 nurses working in all settings responding to the Scoping Workplace Aggression in Nursing (SWAN) Study reported experiencing some form of physical or verbal abuse and believed it affected the quality and productivity of their work (Farrell & Bobrowski, 2003). Benveniste, Hibbert, and Runciman (2005) used data from the Australian Incident Monitoring System (AIMS) and found that 9% of all patient safety-related incidents involved patients and physical violence or violent verbal exchange.

A survey of 233 nurses in Turkey reported that 80% had been verbally abused in the previous year, with the highest rates being in intensive care units (ICUs) and outpatient clinics (Oztunc, 2006). There was no formal system for reporting abuse. Hegney, Eley, Plank, Buikstra, and Parker (2006) surveyed 3,000 nurses in Queensland, Australia, in 2001 and 2004. The comparison between surveys showed increasing levels of workplace violence, and although nurses were aware of workplace policies that supposedly dealt with violent incidents, they were thought to be inadequate. In Japan, severe psychological distress was reported when nurses in psychiatric units were exposed to violence and verbal abuse (Inoue, Tsukano, Muraoka, Kaneko, & Okamura, 2006). An underestimation of the level of sexual harassment nurses face in Japan has also been reported (Hibino, Ogino, & Inagaki, 2006). In Iraq, a small descriptive exploratory study showed 42% of nurses had been physically attacked, mostly by relatives of patients, and 14.3% of attacks were with a lethal weapon (AbuAlRub, Khalifa, & Habbib, 2007). In Canada, a study of pediatric nurses showed that 94% had experienced verbal abuse in the previous 3 months; yelling was the most common form

(Pejic, 2005). Also in Canada, a rare study that linked perceptions of violence with practice outcomes (O'Brien-Pallas et al., 2004) found a higher incidence of delayed nursing interventions when individual nurses experienced violence or when there was a high incidence of violence on the unit. In a small Australian qualitative study, Farrell (1997) found that relatives and doctors were more likely to be aggressive toward nurses than patients, and that nurses were more distressed by abuse from peers. A quantitative follow-up study with a much larger sample (N=270) confirmed these findings (Farrell, 1999).

It is difficult to determine the actual incidence and prevalence of violence toward nurses because there are many different definitions of "violence" and even more ways of collecting data, from self-reports to secondary analysis of workers' compensation claims. Differences in reporting periods are common. Further, it has been in the interest of some professional organizations and labor unions to highlight violence in the workplace as a way to argue for their role in protecting their members (Genovese, 2003), which may produce inflated rates. There has been no concentrated attention to violence on general medical-surgical inpatient wards, nor has violence toward nurses been examined for its relationship to qualities of the working environment or patient care outcomes.

Overview of the Study

The present report is a secondary analysis of data collected in two large studies (Duffield et al., 2007, 2009). The conceptual framework included concepts of nursing resources, workload, the working environment and patient outcomes without predictions of specific links. Violence in the workplace was one of the concepts measured in the "working environment" context.

Staffing and patient data were collected on 94 randomly selected medical and surgical wards in 21 public hospitals across two Australian states between 2004 and 2006. A medical-surgical unit could have been exclusively medical or surgical or a combination of both. EDs, ICUs, and pediatric, obstetric, and psychiatric units were excluded. Data were collected for 7 consecutive days on each unit.

All nurses (full-time, part-time, and agency) on the selected wards in both geographic locations were asked to complete a survey (a total of 3,099 potential consenting respondents; overall response rate 80.3%). Nurses included in the study were clinical nurse specialists (CNS); registered nurses (RNs), enrolled nurses (ENs); and assistants in nursing (AINs). Trainee enrolled nurse (TEN) data were also collected. Ethics approval was gained from the university, participating health services, and respective state health departments (18 committees in total).

Data collected for the study included two self-reported surveys: individual nurse data from the nurse survey comprising the 49-item Nursing Work Index-Revised (NWI-R; Aiken et al., 2001; Estabrooks et al., 2002; Sochalski, Estabrooks, & Humphrey, 1999); job satisfaction; nurses' intention to leave their present position; and three questions about perception of violence over their five most recent shifts.

Shift data were captured using a survey that included the Environmental Complexity Scale (ECS; O'Brien-Pallas, Irvine, Peereboom, & Murray, 1997; O'Brien-Pallas et al., 2004) and 11 questions on nursing interventions that were delayed or left undone at the end of each shift. Comprehensive staffing data including skill mix were obtained from the ward roster-schedule records, and adverse events (falls, medication errors with and without consequences) were obtained from concurrent medical records, or, where available, by examination of data produced by the ward adverse events reporting mechanism. Permission to use all instruments was obtained from the original investigators.

The NWI-R identifies organizational attributes that have been associated with higher patient satisfaction, lower mortality, lower nurse emotional exhaustion, and lower incidence of needle stick injuries (Aiken & Fagin, 1997). We used the 49-item scale and five subscales; autonomy, leadership, resource adequacy, control over practice, and nurse-physician relations (O'Brien-Pallas et al., 2004). Cronbach's alpha for subscales in the present study ranged from 0.63 to 0.83. The ECS measures tensions nurses experience in providing care (O'Brien-Pallas et al., 1997). It has 22 items and taps three domains: unanticipated delays in response to others leading to resequencing of work; unanticipated delays due to change in patient acuity; and delays due to the characteristics and composition of the caregiver team. Cronbach's alpha for these subscales in the present study ranged from 0.56 to 0.82.

Trained nurse data collectors collected patient and staffing data daily on each unit for 7 days. The PRN-80 measure of nursing acuity (Chagnon, Audette, Lebrun, & Tilquin, 1978a, 1978b; Tilquin, Carle, Saulnier, & Lambert, 1981) was completed from concurrent medical records by data collectors. A measure of nursing supply and demand was calculated as the difference between the caregiver hours required by patients on the PRN-80 and the hours of staffing supplied. Data collectors also gathered data on patient adverse events as falls and medication errors.

Data were analyzed using SPSS version 16 (SPSS Inc., 2007). Missing data were imputed as the ward mean, or

where more than 10% of data were missing, that variable was not used in analyses. Individual nurse and ward descriptive statistics were first obtained on the data. These were then aggregated to the ward as the common level at which patient and nurse data could be compared. Categorical variables were transformed into the proportion of X per ward (e.g., the proportion of nurses with a bachelor's degree or higher). Continuous variables such as the subscales of the NWI-R and ECS were calculated as the ward mean. Explanatory variables were added to statistical models in sequence, and the properties of each newly expanded model were compared to those of the previous one (using the −2 log likelihood value). The order of entry of variables into the statistical modeling was consistent with the conceptual framework noted earlier. Following aggregation, Poisson regression models were conducted in the case of low event counts of patient outcomes. Complete staffing data were not available on four wards, and they were excluded from correlation and regression analyses. The final sample for regression and correlation analyses was therefore 90 wards. Only variables with statistically significant relationships are presented here.

Findings

Respondents to the nurse survey were predominantly registered nurses (72.3%), including nursing unit managers (NUMs) and a small number (n=16) of clinical nurse educators (CNEs) or clinical nurse consultants (CNCs; equivalent to clinical nurse specialists in the United States), with 533 ENs (21.5%), 75 TENs (3%), and 63 AINs (2.5%). The overall response rate was 80.3%.

As part of the nurse survey, nurses were asked about their experience of violence: "In the last 5 shifts you worked, have you experienced any of the following while carrying out your responsibilities as a nurse?" The response was "yes" or "no" to physical assault, threat of assault, or emotional abuse (**Table 1**).

When calculated as a percentage of responding nurses per ward, up to 50% of nurses perceived physical violence; up to 66%, threat of violence; and up to 65%, emotional abuse. In contrast, 11 wards showed no perceptions of physical violence and 6 no threats. The lowest rate for perceptions of emotional abuse was 5%.

Table 1. Nurses Experiencing Violence in the Last Five Shifts

	Frequency	Percent
Physical violence	356	14.4
Threat of violence	515	20.8
Emotional abuse	947	38.2
N	2,478	

Table 2. Source of Violence Towards Nurses

	Physical violence (%)	Threat of violence (%)[a]	Emotional abuse (%)[a]
Patient	88.4	77.6	39.6
Patient + family/visitor	6.8	10.2	16.1
Family/visitor	2.5	8.3	14.7
Nursing co-worker	1.1	2.0	14.7
Patient + nursing co-worker	0.6	0.2	4.1
Physician	0.0	0.2	1.0
Combinations of the above	0.6	1.6	9.8
Number of nurses[b]	356	515	947

[a]Percentage of nurses reporting violence who experienced each category. [b]*N=2,478.*

Respondents were also asked to choose the source of perceptions of violence from a provided list. Patients and families were responsible for most physical assaults and threats of assault. The majority of emotional abuse was also from patients and their families, but up to a fifth was reported from co-workers (**Table 2**).

Correlation analysis suggested a number of associations between variables (**Table 3**). Perceptions of violence correlated with subscales of both the NWI-R and

Table 3. Correlation of Ward Environment Factors per Ward and Proportion of Nurses Experiencing Violence

	Physical violence	Threat of violence	Emotional abuse
Autonomy[a]	−0.10	−0.01	−0.26*
Nurse-doctor relations[a]	−0.18	−0.27**	−0.18
Leadership[a]	−0.01	0.04	−0.24*
Unanticipated changes in acuity[b]	0.21	0.32**	0.07
Amount more time needed to complete work per shift[b]	0.14	0.27**	−0.02
Tasks delayed per shift[b]	0.17	0.26*	0.24*
Tasks not done per shift[b]	0.32**	0.34**	0.27*
Nursing demand/supply[c]	0.24*	0.24*	0.12
Percentage RN hours per ward	−0.27*	−0.22*	0.08
Percentage EN hours per ward	0.28**	0.24*	−0.08
Percentage nurses with bachelor's degree or higher	−0.22*	−0.10	0.05
Percentage patients with a planned admission	−0.29**	−0.37**	−0.07
Percentage patients waiting for a care facility	0.15**	0.44**	0.07
Percentage of nurses intending to leave current job	−0.14	−0.21*[b]	−0.21*

Note. EN, enrolled nurse; RN, registered nurse. [a]Nursing Work Index–Revised: Autonomy, Nurse-doctor relations, Leadership. [b]Environmental Complexity Scale: Unanticipated changes in patient acuity. [c]Nursing hours of care required per patient / nurse hours per patient day. *$p \leq .05$, two-tailed. **$p \leq .01$, two-tailed.

the ECS, but in different patterns. Emotional abuse was lower when leadership and nurse autonomy were higher. As there were more unanticipated changes in patient acuity, emotional abuse was increased. As emotional abuse increased, so did the amount of additional time required to complete nursing work per shift, and the number of delayed tasks. Positive relationships between nurses and doctors were negatively correlated with the threat of violence. The number of nursing tasks not completed each shift was associated with increased levels of all types of violence. As the difference between the amount of nursing care required by patients and the amount of care available increased, the rates of both physical violence and threats increased. A richer skill mix (percentage of RNs) was also linked to fewer instances of perceptions of physical or threatened violence, and the proportion of nurses with a bachelor's degree or higher was associated with less perceived physical violence. There was no relationship between the response rate of the ward and perceptions of violence.

There were also operational considerations. As the proportion of patients on the ward waiting for a care facility increased, the proportion of nurses experiencing physical violence or the threat of violence also increased. Conversely, as the proportion of planned admissions increased, physical violence and the threat of violence decreased. Finally, emotional abuse correlated positively with the nurses' intent to leave the current position.

Correlation analysis of violence and patient adverse events found several positive associations. Physical violence was associated with falls, medication errors, and late administration of medications. Threats of violence were linked to both falls and medication errors (**Table 4**).

Although these associations must be viewed with caution due to the low rates for adverse events, some correlations were supported by Poisson regression analyses specific to outcome measures with low rates. All types of violence were linked to late administration of medication, and the threat of violence was associated with falls and medication errors (**Table 5**). Structural variables of hospital or unit size or rural or urban location were never significant in statistical models.

Table 4. Correlation of Patient Adverse Events per Ward and Nurses Experiencing Violence

	Physical violence	Threat of violence
Falls	0.21**	0.19*
Medication errors	0.22**	0.22**
Delayed administration of medication	0.15*	0.10

*$p \leq .05$, two-tailed. **$p < .01$, two-tailed.

Table 5. Poisson Regression of Violence on Patient Adverse Events

	Physical violence	Threat of violence	Emotional abuse
Falls	—	1.02 (1.01–1.03)[a]	—
Medication errors	—	1.02 (1.01–1.02)	—
Late administration of medication	1.02 (1.01–1.02)	1.02 (1.01–1.02)	1.01 (1.01–1.02)

Note. Confidence interval in parentheses. All ratios are significant at $p \leq .05$. [a]Incidence Rate Ratio: For a one unit increase in threat of violence, the rate ratio for falls would be expected to increase by a factor of 1.02.

Discussion

The incidence of self-reported violence toward nurses averaged 30% per nursing unit for emotional abuse and about half that for threats or actual assault. However, there was a very wide range across units, suggesting that violence is related less to patient populations than it is to unit circumstances. Since all units in this study were medical/surgical units, clearly violence is not restricted to psychiatric units or EDs, where it has been most studied.

The analyses showed that as ward environments become less stable (fewer registered nurses, increased workload and unanticipated changes in patient needs, decreased perception of nurse leadership, lower nurse autonomy, poorer relations with doctors, more patients awaiting placement), perceived violence increases. Nurses are more likely not to deliver medications on time or commit (self-reported) medication errors, and the tension in the work environment is associated with increased patient falls, perhaps because nurses' surveillance of potentially troublesome patients decreases.

The difference between perceptions of emotional abuse and threatened actual or physical assault are intriguing. Emotional abuse did not correlate well with measures of the working environment or with patient outcomes, but it does correlate with intent to leave the present position. One interpretation might be that nurses tolerate emotional abuse in contemporary highly charged clinical environments but intend to move out when they can. Emotional abuse does not seem to disturb nursing practice as much as physical assault or threat thereof.

Still, the extent of emotional abuse, threats of physical violence, and actual assault are not well known either in nursing or in larger public forums. Studies to quantify the prevalence of secondary psychiatric diagnoses including

alcohol, substance, and tobacco use disorder on medical-surgical units would shed light on this aspect of nursing workload. The American Nurses' Association Nursing Database for Nursing Quality Indicators (NDNQI) collects data on patient assaults but only for psychiatric units (American Nurses Association, 2007). The data collection requirements would be an additional burden on medical-surgical units not used to assessing patients for assault potential. The negative relationship between the proportion of bachelor of science in nursing (BSN) staff and violence suggests that violence can be managed, given appropriately educated staff.

Hegney et al. (2006) reported an increase in workplace violence in Queensland (Australia) between 2001 and 2004, and while the majority of perpetrators were patients, the researchers acknowledged that the data were not collected at the ward level, so it was impossible to identify violent "hotspots." The prevalence of violence and threat in the present study is higher than that in the studies by Hegney et al. and O'Brien-Pallas et al. (2004). Hegney et al. offer two reasons for the rates. The privacy guidelines and legislation in their state, similar to those in most states in Australia (and the Health Insurance Portability and Accountability Act [HIPAA] in the United States), meant that staff were less able to provide information to relatives, resulting in increased rates of violence from relatives and visitors. There are programs underway that address issues of violence toward health professionals (Forster, Petty, Schleiger, & Walters, 2005; Grenyer et al., 2004). Some educate staff in aggression minimization strategies (Beech, 2001; Cowin et al., 2003; Korow, 2008). Some construct tools for identifying violent patients (Anderson, Bell, Powell, Williamson, & Blount, 2004; Garrett & Rowe, 2004; Kling et al., 2006; Lamberg, 2007; Lomas, 2007). Some deal with culture-changing interventions that encourage reporting of incidents and management support strategies (Kitchener, Sykes, & McEwan, 2004). Most of this work is in mental health or emergency settings. The medical/surgical setting as studied here presents particular problems that may be unattended because it is hard to believe sick patients and their families would ever be abusive toward nurses. The adequacy of workplace policies to deal with violence are often variable, indicating there is potential for improvement in some facilities (Hegney et al.).

Finally, the Center for American Nurses (2008) has recently issued a policy statement on bullying. The Joint Commission on the Accreditation of Healthcare Organizations (2002) in the United States has implemented standards that apply to all settings, including home care and urgent care centers to focus attention on security issues including workplace violence. The standard requires accredited agencies to address disruptive behavior by any employee or participating physician.

Limitations

The study is limited by self-reports of both violence and measures of tasks not done or delayed and intent to leave the present position. Unit level primary data collection was constrained by a 7-day data collection period and may have missed some instances of falls or medication errors that occurred before or after patient stays during the data collection period. Patient adverse outcome rates were very low, which limited statistical power. While all of the units studied were medical-surgical, data on the exact mix of case types by unit were not analyzed.

Conclusions

Violence in the medical/surgical workplace is related to deficiencies in nursing practice and negative patient outcomes. The data presented here suggest that perceptions of violence are less associated with patient populations than with qualities of the working environment. That, along with hints that a better prepared nursing staff (percentages of RNs and BSNs) can moderate violence suggests that violence does not have to be "just a part of the job" for nursing, but can actually be managed.

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Clinical Resources

- Center for American Nurses. (2008). Policy statement on lateral violence and bullying in the workplace. http://www.centerforamericannurses.org
- Glueing it together: Nurses, their work environment and patient safety. http://www.health.nsw.gov.au/pubs/2007/nwr_report.html
- Joint Commission on the Accreditation of Healthcare Organizations. Security issues for today's healthcare organizations. http://www.jointcommissioninternational.org
- World Health Organization. Workplace violence in the health sector. http://www.who.int/violence_injury_prevention/violence/interpersonal/WVstresspaper.pdf

Glossary

CNS: a personal grade awarded to individual nurses on the basis of expertise in a specialty demonstrated by qualifications and/or experience (NSW Health, 2005)

EN: requires one year paid vocational training incorporating 15 weeks at a technical college for theoretical training and the balance in clinical units, and is equivalent to LVN/LPN

AIN: equivalent to patient care assistants (PCA)

TEN: trainee enrolled nurse, employed by the hospital for vocational training following technical college

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